TOWARD AN UNDERSTANDING OF THE ORGANIZATIONAL LIFE COURSE AND CULTURE OF A COMMUNITY COALITION

By

SABRINA NICHELLE SCOTT

A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2003

Copyright 2003

by

Sabrina Nichelle Scott

This dissertation is dedicated to my paternal grandmother and my maternal grandmother:

Mrs. Rosebud Fryer Scott

and

Mrs. Lillian Ruth Blackwell

ACKNOWLEDGMENTS

I want to thank the members of my doctoral committee for their patience and support throughout the years I spent doing fieldwork and writing my dissertation. I am very appreciative of the time and commitment of my dissertation chair, Professor Otto Von Mering. I want to especially thank Dr. Elizabeth Briody for her interest and enthusiasm in my research, and for her close guidance and feedback throughout the dissertation writing process. I thank Professor Robert Weiler for his insightful suggestion and Professor Paul Doughty for his participation on my dissertation committee.

I am very grateful for my family members who never failed to encourage me. I know that I am very blessed to have supportive relatives: my mother, Mrs. Odessa Crawford; brother, Mr. Jason Crawford; great aunt, Mrs. Daisy Dee Mercer; aunts, Mrs. Rebecca Ruffin, Mrs. Pamela Rose; uncle, Mr. Leslie Rose; cousins, Ms. Tracy Ruffin, Mrs. Anita Gray, Mr. Khaliq Drew, Mrs. Denise Drew, Mrs. Martina Salmon; Mrs. Constance Senior, Miss Michelle Senior, and godmother Ms. Laurel Dandridge. I want to especially thank my sister Ms. Natalie Krider for her unending support, and my cousin Ms. Leneeqa Jordan for proofreading several chapters. I would have never completed this dissertation without the perpetual prayers and financial support of my grandmothers, Mrs. Rosebud Fryer Scott and Mrs. Lillian Ruth Blackwell.

I appreciate my team of friends for cheering me on throughout the high and lows of writing my dissertation. I thank Mrs. Louisa Ko, Mrs. Brendetta Andrews, Ms. Blossom McHayle, Mrs. Tammy Tripp, Ms. Linda Lacy, Ms. Maxine Downs, and Ms. Ina

Tjandrasuwita. I especially want to thank Dr. Barbara Brice, Dr. Sadie Sanders, Ms. Nancy Clark, Ms. Mahalia Joseph, and Mrs. Zoretta Hopkins for giving me feedback on my research, and/or reading portions of my dissertation. I thank Dr. Ruth Britton for sharing words of wisdom and encouragement.

I want to thank former co-workers for their interest and encouragement in writing my dissertation. I thank Jose, Thomas, Jameela, Morris, Jeff, Linda, Leroy, Fred, Carl, Bill, LaChonne, Conrad, Michelle, Stanley, Shirley, Charise, Betty, Ed, Rory, Nick, Sheila, Edith, Gary, Zaynab, Vada and Mary Anne (last names withheld to protect identity). I am very grateful to Mr. Ron LaJoie for proofreading and editing this dissertation.

Most importantly, I want to thank the Lord Jesus Christ who is my savior, strength, and provider. Jesus is worthy of all honor, glory, and praise. I would have never made it on my own.

TABLE OF CONTENTS

page

LIST OF TABLES

LIST OF FIGURES

Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

TOWARD AN UNDERSTANDING OF THE ORGANIZATIONAL LIFE COURSE AND CULTURE OF A COMMUNITY COALITION

By

Sabrina Nichelle Scott

May 2003

Chair: Otto Von Mering
Major Department: Anthropology

This ethnographic study describes and seeks to explain how a community coalition partnership tried to mobilize to plan intervention programs to address teen pregnancy. This dissertation documents from October 1, 1995, to September 30, 1996, the processes that occurred during several stages during the initial life course of the Jacksonville Alliance, a community coalition. The "classic" ethnographic field study method has proven to be useful in describing and explaining the sequence of actions and the outcomes from the coalition's efforts.

The customary agency-focused service model familiar to coalition members was incompatible with the sponsoring and funding source's intention. This study provides an understanding of difficulties in mind set and structure when applying the Centers for Disease Control (CDC) Community Coalition Partnership model in Jacksonville, Florida.

The CDC Partnership model could not be successfully implemented for three reasons: (1) a paradigm shift from the traditional service model to a partnership model did not occur within the community coalition, (2) organizational fragmentation within the Jacksonville Alliance was pervasive, and (3) a partnering arrangement did not evolve between the Jacksonville Alliance and the targeted community.

In light of the ethnographic findings, this study proposes an alternative "ideal-typical" model for coalition development to counteract fragmentation. The model emphasizes the cultural dynamics of reciprocity and coalescence within the functional structure of community coalition development.

There are two general conclusions from this ethnographic work. First, fragmentation in the community coalition tends to reflect the fragmentation that already existed in the "Jacksonville community," and to varying degrees throughout American society. Second, there was an inherent conflict over ways to redistribute or reallocate goal-oriented activities to reduce teen pregnancy and move beyond the traditional human service model in order to align these activities with the CDC Partnership model.

Given the above research-based conclusions, four recommendations are suggested. These recommendations encourage coalition members to shift from dependent and uni-directional to interdependent, bi-directional relationships of socio-economic partnering and reciprocity. Three areas of future research are proposed.

CHAPTER 1
INTRODUCTION

Each year about one million teens become pregnant in the United States (Kirby, 1997). In September 1995, the Centers for Disease Control and Prevention (CDC) awarded cooperative agreements to 13 communities across the United States to support the efforts of community-wide coalition partnership programs that work with youth to delay pregnancy and childbearing. Under the CDC's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy, designated "hub organizations" received federal funds for a two-year planning period (Phase I). Hub organizations are agencies that agreed to lead local community coalition partnerships among concerned social service, denominational, educational, health, and business related agencies.

The purpose of CDC funding was 1) to support the efforts of hub organizations to enhance their capacity to strengthen and evaluate the effectiveness of coalition partnership programs, and 2) to develop community action plans to implement comprehensive community programs for the prevention of initial and repeat teen pregnancies and related problems (CDC, 1995). Recipients were to establish demonstration projects to plan for implementing programs to prevent adolescent pregnancy. However, funds were not to be used to support direct services to teens (e.g., contraceptives, reproductive counseling).

After two years of planning (Phase I), the CDC intended to award competitive awards to approximately six of the participating communities to support the implementation of their pregnancy prevention programs during Phase II. However, all 13

communities received funding for implementation (Phase II) because of increased congressional funding. The timeframe for Phase I was from October 1, 1995, through September 30, 1997. The timeframe for Phase II was October 1, 1997, to September 30, 2002.

The Division of Reproductive Health, one of the eight divisions within the National Center for Chronic Disease Prevention and Health Promotion within the CDC provided administrative and technical support for its national teen pregnancy prevention initiative. Using the medical model (Burdell 1998; Rodriquez and Moore 1995; Warshaw 1989), CDC viewed teen pregnancy as a disease that had to be eradicated. Funding was predicated on the existence of a "problem" or "disease." CDC saw teen pregnancy linked geographically and imposed structural constraints on recipients that received their funding.

Awardees were reported as serving communities of at least 200,000 people where teen birth rates were at least 50 percent above the national average of 62.1 births per 1,000 women 15-19 years of age. Communities selected to participate in the CDC's national initiative included Yakima, Washington; San Bernardino, California; Chicago, Illinois; Milwaukee, Wisconsin; Kansas City, Missouri; Oklahoma City, Oklahoma; San Antonio, Texas; Rochester, New York; Boston, Massachusetts; Pittsburgh, Pennsylvania; Philadelphia, Pennsylvania; Orlando, Florida; and Jacksonville, Florida.
The CDC awarded the Duval County Public Health Unit (now Duval County Health Department (DCHD)) approximately $500,000 for two years to support its efforts as the hub organization in Jacksonville, Florida. This dissertation chronicles and interprets the first year of Phase I of the CDC-funded community coalition partnership in Jacksonville.

Statement of Problem

The community approach in using a coalition as an intervention strategy for a public health issue such as teenage pregnancy is based on the behavioral science assumption that incorporating various sectors of the community (e.g., religious, business, education, media, parents, teens) will produce beneficial comprehensive programs (Florin et al. 1993). This assumption is put to the test in this study on the basis of a longitudinal ethnographic examination of a community coalition during its initial development phase.

Purpose of the Study

The purpose of this study is to: (1) document and explain the events that occurred in the initial organizational life course of a community coalition, (2) extend an existing stage model of coalition development to include cultural dimensions, and (3) provide recommendations to assist in the development and coalescence of future community coalitions. The organizational life course is viewed as a process of coalition development.

In order to understand the early cultural life course of a community coalition, the following research questions were posed:

- How did the community coalition come into existence?
- How did the community coalition establish its organizational structure?
- How did the community coalition increase its ability to act?
- How did the community coalition plan for action?

Significance of the Study

My research adds to the existing literature in anthropology, health education, community and organization development by describing and explaining the challenging events that occur when coalition members attempt to work together, i.e., form partnerships of action. The findings from this research are relevant because many federal

programs require the establishment of community coalition partnerships as a prerequisite to the receipt of federal funding. Millions of dollars have been invested in coalition development as a health promotion intervention (Butterfoss et al. 1993:315).

This study provides an understanding of the application of the CDC Community Coalition Partnership model in Jacksonville. This dissertation describes and seeks to explain how a community coalition partnership tried to mobilize to plan intervention programs to address teen pregnancy. The findings illustrate the stark divisions throughout all levels of partnering associated with the community coalition. This research demonstrates the need to reexamine the concept of partnering as elaborated in the extant literature and to reassess the ways in which that concept is applied in community settings.

Toward this end, this study demonstrates the inadequacy of the stage model of coalition development and proposes an alternative "ideal-typical" model for the development and effectiveness of a community coalition. This involves the presentation of the cultural (e.g., ideological and/or behavioral) and organizational-structural dimensions of such an ideal model.

Data Methods, Data Collection and Recording

This research study is based on the traditional ethnographic method and the basic tenets of anthropological community study methods. A sequential body of data was recorded in my field notes as a participant observer as well as through my role of non-participant observer listener. The collected field notes, organizational documents and coalition-meeting minutes were combined and provided a complete record of events during the formation of the community coalition. All relevant data were shaped into

"committee profiles," and all organizational records were arranged according to standard categories.

Data Analysis

The data analysis involved compilation of expected coalition activities (by CDC) and actual coalition activities. In addition, the data analysis included the creation of committee profiles, and content analysis of all field and documentary data. Likewise, the data analysis involved comparing and contrasting the conceptual framework of Florin et al. (1993), "Identifying Technical Needs In Community Coalitions: A Developmental Approach," to field and documentary data. The following sections provide an overview of the CDC program requirements and the grant application of the Duval County Health Department.

CDC Program Requirements

CDC Program Announcement 547 sets the guidelines and expectations of the Community Coalition Partnership for the Prevention of Teen Pregnancy. The program requirements provide the context of the community partnership that began in Jacksonville on October 1, 1995.

According to Announcement 547, a "hub organization" of an existing teen pregnancy prevention community coalition (i.e., three or more private, nonprofit and/or local organizations) could submit an application to participate in the CDC national initiative. A hub organization was to involve all relevant organizations in the community to work in partnership to prevent teen pregnancies.

CDC suggested the general approach to pregnancy prevention programs was to involve teens in community service, job skills development, and other performance opportunities that build their self-esteem. Likewise, the community coalition partnership

program was to reach the greatest proportion of teens possible within the community, giving emphasis to teens that are in high-risk situations. However, possible high-risk situations were not delineated in CDC Program Announcement 547.

The CDC recommended that programs should strive to provide teens that are not sexually active with a strong incentive to remain abstinent. Teens who were sexually experienced were to be provided with a strong incentive to delay pregnancy. For sexually active teens, programs were to promote the consistent and effective use of appropriate contraceptives.

CDC Program Announcement 547 also outlined activities that the "recipient" (i.e., the hub organization) was responsible for the conduct of the work required to achieve the purpose of the pregnancy prevention program. The hub organization was to coordinate efforts of coalition members and facilitate the development of partnerships. During year one of the grant, the hub organization was to work with partner organizations to involve teens in a meaningful way to plan for the implementation of pregnancy prevention programs. The program announcement 547 explicitly stated the following requirements:

1. Conducting a needs assessment.
2. Identifying effective intervention methods and adapting them to the target community.
3. Specifying criteria that will be used to identify teens that are at greatest risk of becoming pregnant or getting someone pregnant, and link teens to appropriate prevention services.
4. Field testing intervention components and modifying the components based on the results.
5. Prioritizing the gaps in services as well as teens in need.
6. Developing a community action plan that establishes realistic objectives, partner roles, sources of sustainable funding, coordination mechanisms, approaches to targeting resources and services, schedules for accomplishing tasks and a

delineation of responsibilities, and plans for evaluating progress and indicators of effectiveness.

CDC Program Announcement 547 outlined activities that the CDC was responsible for in achieving the purpose of the pregnancy prevention program. CDC listed the following activities as its input in the project proceedings:

1. Providing consultation and technical assistance to recipients with respect to program activities.
2. Facilitating the development of a national partnership between private and public sector organizations in support of community coalition partnership programs to prevent teen pregnancy and related problems.
3. Coordinating the planning and support of at least two planning, progress evaluation, demonstration, training, and/or dissemination workshops together with recipients and national partners.
4. Promoting and collaborating in the transfer and dissemination of information, methods, and findings developed as part of this program.

Duval County Health Department (DCHD) Grant Application

The DCHD stated in its grant application that it met all of the qualifications for eligible hub organizations. DCHD proposed to reduce teen pregnancy in eight targeted zip codes in Jacksonville with the highest teen birth rates. The eight zip codes with the highest teen birth rates had birth rates that were 1.5 times higher than the national average.

According to the grant application, the population in the targeted areas (i.e., targeted zip codes) was 218,133, and the overall teen birth rate for targeted communities was 103 with a range of 52 to 185 live births per 1,000 females age 15-19 years (1992-1994 data). The birth rates in the eight zip codes cumulatively exceeded the national average of 62 by nearly 70 percent. As a result of the high teen birth rates in the eight

targeted zip code areas, Jacksonville qualified to participate in the CDC national initiative.

The DCHD defined "community" demographically as several high-risk neighborhoods that constituted a contiguous community of eight zip codes forming Jacksonville's urban core. In its grant application, DCHD did not identify any neighborhoods, only eight zip codes forming Jacksonville's urban core (32202, 32204, 32205, 32206, 32208, 32209, 32210, 32254). Besides high teen birth rates, no other measures of high-risk teens (e.g., high truancy rates, crime) were mentioned in the grant application to identify these teens that were most likely to become pregnant. DCHD stated in its application that although it was going to target high-risk neighborhoods, the services and resources to be developed would apply to the entire Jacksonville community.

The grant application identified six outcome objectives for Year 1. Outcome objective six continued into Year 2. The six outcome objectives were the following:

1. Establish administrative and operational structures,
2. Complete needs assessments including statistics and resources,
3. Identify, pilot, and evaluate prevention strategies and programs,
4. Develop and pilot identification and triage protocols for at-risk youth,
5. Field test and modify prevention services,
6. Develop and implement a community action plan.

DCHD's application designated the First Coast Adolescent Health Consortium (FCAHC) as Jacksonville's community coalition to address teen pregnancy prevention. FCAHC agreed to serve as the community coalition and to be the designated partner with DCHD as the hub organization for the CDC national initiative in Jacksonville.

DCHD and the University of Florida Department of Pediatrics had founded FCAHC in 1994. FCAHC was comprised primarily of representatives of health and

social services organizations, and individuals interested in improving adolescent health in Jacksonville.

In the summer of 1995, in order to demonstrate coalition partner support and to strengthen DCHD's grant application, 32 organizations consisting of private, public, and nonprofit local organizations submitted letters of agreement to DCHD in support of the community coalition partnership to prevent teen pregnancy in Jacksonville.

CHAPTER 2
LITERATURE REVIEW

This literature review addresses three topics that are relevant to the research study. First, I examine the definition of "community." How is "community" defined? Different definitions are discussed based on various academic disciplines. Second, theoretical and methodological issues in community studies are reviewed. Community studies as text and community studies as a method are addressed. Third, the extant literature on community coalitions as it relates to communities organizing to address public health concerns is examined. Strengths, weaknesses, and assumptions about community coalitions provided are discussed. Lastly, in order to understand how a community coalition organizes to address a public health issue, a conceptual framework of coalition development is featured.

Definitions of Community

There is no simple definition of "community." Moreover, there is no consensus on the conceptualization of "community." There are two major uses of the term community. The first is the territorial and geographical idea of community. The second usage is relational. The former focuses on community as a place of residence. The latter is concerned with the quality or character of the human relationships, without reference to location (McMillan and Chavis 1986). Some authors view community as a unified, integrated whole, or as composed of many parts and containing separate ideologies (Schwartz 1981). This is a literature review of "ideal typical" definitions of community

from the perspectives of community psychology, sociology, health education, and anthropology.

The Community Psychology Perspective

The literature on community psychology tends to emphasize the formation and persistence of a "sense of community." According to Chavis and Newbrough (1986:335), a community should be defined as any set of social relations that are bound together by a sense of community. In the community psychology literature the conceptual stress is on the psychological processes in achieving a sense of community. The "sense of community" is thought to be a feeling that members have a feeling of belonging, that members matter to one another and to the group, and that there is a shared faith that members' needs will be met through their commitment to be together (McMillan and Chavis 1986).

The Sociological Perspective

Within the field of sociology, there is not a single definition of the concept of "community." In discussing the term "community," John McKnight, a sociologist stated that to some people it is a feeling, to some people it is relationships, to some people it is a place, and to some people it is an institution (CDC 1997:6). From a sociological perspective, therefore, who is included and who is excluded from membership is central to the definition of community (Ibid.). Criteria for membership can be based on geography, shared interests, values and experiences. Sometimes, individuals self-select their community membership so that it is experienced as a "reference groups." At other times, the designation of community member is primarily a matter of being imposed by insiders or outsiders (Center for Substance Abuse Prevention [CSAP] 1997).

The Health Education Perspective

The health education literature, when defining community, incorporates characteristics from the literature of community psychology, sociology and anthropology. A community is a locale or domain that is characterized by the following elements: (1) membership – a sense of identity and belonging; (2) common symbol systems – similar language, rituals, and ceremonies; (3) shared values and norms; (4) mutual influence – community members have influence and are influenced by each other; (5) shared needs and a commitment to meeting them; and (6) shared emotional connection – members share common history, experiences, and mutual support (Israel et al. 1994).

Yet, a segment of the health education literature that focuses on community empowerment includes political dynamics in the definition of community (Eng and Parker 1994). Multiple constituencies and interests within a community must be acknowledged (CDC 1997). A proper understanding of community, therefore, must be based on the fact that various sectors of the community have to be well integrated and interdependent in order to address a community's complex health problems and quality of life issues (Ibid.).

The Anthropological Perspective

As in sociology, there is no single definition of the term "community" in anthropological literature. Historically, anthropologists have focused on peoples of the world where kinship systems are the basis of their social structure. Anthropologists now study populations where kinship is no longer the principal determining factor in social organization. According to Warner and Lunt (1941:16), "the researcher among simpler people terms their communities 'tribes,' 'bands,' 'villages,' or 'clans;' the social scientist

who studies modern life designates certain of the local groups as 'metropolitan areas,' 'cities,' 'towns,' 'neighborhoods,' 'villages,' and 'rural areas.'

The ethnographic tradition usually has defined "community" as a "complete territorial community" (Hall 1988:21-22). Many anthropologists have described communities that had distinct geographical boundaries along with institutional sectors that enabled its members to be self-sustaining and independent of chiefdoms, states, and nation-states. Yet, contemporary ethnographies about communities within complex societies challenge the definition of the "community" as a "complete territorial community" (see Liebow 1967; Valentine 1978). Outsiders such as national governmental officials are influential in redefining boundaries and determining resources that are available to people. As a result, many communities that ethnographers have described are not "complete territorial communities" (see Hochschild 1973; Stack 1974).

Symbolic anthropologists, on the other hand, are not concerned with the territorial and geographically complete community but the symbolic construction of community (Cohen 1985; Gregory 1983). They are more interested in what the boundary means to people and what meanings they give to it (Cohen 1985:12). When a consciousness of community is said to exist, it refers to shared perceptions of its boundaries, that is to say, boundaries which are themselves largely constituted by people in interaction (Ibid).

Community Studies

In general, community study is the study of human behavior in communities, in the sense that people exist in natural contexts made up of natural and full human co-operative living, that they live in intergenerational and intersexual relationships, and that they engage in ongoing cultural and interfamilial communication and transmission (Arensberg 1954).

Community study has been viewed as a research method and as text based on the ethnographic tradition. As a rule, the community study method involves first hand investigation through participant observation of small discrete communities. As text, community study refers to the thorough (i.e., complete) description and analysis of a community. The literature review examines both the method and text approaches in community studies and the related theoretical issues.

Community Studies As Text

Community studies as text examine a community as a group and the community as a place. "Single-community studies represent the most abundant type of ethnographic research in anthropology, ranging over the map from villages in India to a single band of Bushmen on the Kalahari Desert" (Spradley 1980:29-30). Although there are studies of rural and urban communities in Latin America, Europe, Asia, and Africa, the focus in this chapter that is relevant to the study at hand is the community studies in America. The academic literature on American communities is voluminous and varies in scale.

Some scholars have explored American communities by emphasizing national values and behaviors. Gorer's The American People, A Study In National Character (1964) is representative of the national character and personality school. Hall and Hall (1989) posit this theoretical position in analyzing various aspects of American culture. Central to the national character of Americans regardless of the typologies of American communities (Arensberg 1955) is individualism (Bellah et al., 1985; Bender 1978; Gorer 1964; and Hochschild 1973).

Connected with individualism is the drive for increased status and upward mobility. This drives, as "evidenced in their stance, dress, posture, attitude, voice level and possessions – is one of the reasons why Americans are readily identifiable anywhere in

the world" (Hall and Hall 1989:149). The drive for increased status and upward mobility as part of the national character is viewed collectively and individually across race and class. Community studies of ethnic minorities tend to reflect these macro-core values.

The struggle for increased status and upward mobility is also examined in Whyte' s Street Corner Society: The Social Structure of an Italian Slum (1981 – Third Edition). This is evident by activities documented by Whyte in social ranking within the gang, social mobility, political rallies, racketeering, and other existing social clubs within the Italian community of Cornerville.

Ethnographies of African-American communities in the rural South or urban North depict the barriers to increased status and upward mobility experienced both as a group and as individuals. Dollard's classic work on social relations between whites and blacks in Caste and Class in a Southern Town (1949) explores the social boundaries that exist in a Southern town. Barriers to increased status and mobility within and outside the African American community were not only perpetuated by social boundaries but became entrenched through economic exploitation, political control, and physical segregation of African Americans.

These issues are described and analyzed in detail through the lives of African American men in Liebow's Tally's Corner: A Study of Negro Streetcorner Men (1967), Valentine's Hustling And Other Hard Work: Lifestyles In The Ghetto (1978) and the lives of women in Stack's All Our Kin: Strategies for Survival in a Black Community (1974). The psychological consequences given the barriers to increased status and upward mobility are evident in these community studies of African Americans.

Lloyd Warner and Lunt (1941) in the Yankee City series explore individual and collective issues of status and upward mobility. Warner and Lunt describe markers of increased status and mobility within the community. For example, Warner and Lunt are careful to describe the physical structures of the houses in different neighborhoods of "mainstream" America. Physical markers (e.g. type of houses) serve as geographic boundaries that separate one community from another. Residential communities in America are ranked in status based on the social stratification of its inhabitants.

Like the ethnographies of Liebow (1967) and Valentine (1978), Sennett and Cobb's The Hidden Injuries of Class (1973) explores the negative psychological ramifications of those who increase their status by leaving their community in order to become upwardly mobile in middle America. Sennett and Cobb describe individuals who experience isolation, shame, guilt, and a lack of belonging to their new communities.

Other Theoretical Approaches

In addition to the national character and personality school in examining American communities, there are other theoretical approaches used in community studies. Warren's The Community In America (1978) is an analysis of older and newer approaches in community studies. He identifies six approaches to the study of community in terms of (1) space or 'territoriality,' (2) people, (3) interaction, (4) social system, (5) shared institutions and values, and (6) distribution of power.

In looking at communities as a matter of spatial arrangement, community studies are divided into rural and urban studies. These studies tend to provide detailed analysis of the different kinds of people who reside in the community. For instance, one community researcher may concentrate on a particular ethnic group. Another may examine the working of a community in terms of social interaction by detailing how the

local people interact with each other. Warren (1978) posits that a social system analysis of community phenomena is useful in looking at the community as a system, i.e., according to particular arrangements of social action and interaction.

The community conceptualized as a matter of shared institutions and values can be seen in the first American community study completed by Lynd and Lynd's Middletown (1929) and Middletown in Transition (1937). Shared values form part of the "glue" that is supposed to hold communities together. These values are not necessarily unique to each community, but also tend to be commonly held values of the larger society (Warren 1978).

The community examined on the basis of its particular distribution of power uses "community power-structure analysis" of personal persuasion, social influence and control practices. This approach is recognized in health education research literature within the domains of community empowerment (Wallerstein and Bernstein 1994). It is based on the observable fact that certain individuals exercise more influence than others. The anthropologist Laura Nader (1988) advocates its use in her thought-provoking article "Up The Anthropologist – Perspectives Gained From Studying Up."

Theoretical Issues in Community Studies

Early community studies portrayed a "geographic community" that had clear boundaries. The community was described as a distinct entity independent of the larger society. This may have been true of small-scale societies. However, in complex societies physical markers are constantly shifting due to the influence of institutions (e.g., governmental, quasi-governmental) that often define the geographic community differently from the residents themselves.

According to Suttles (1972), the community is not just based on the physical structures/markers and cognitive maps of residents, but is also shaped by the perceptions of social institutional entities external to the community. As a result, "the community remains elusive" (Warren 1978:8).

It was assumed that the community exercised autonomy over certain institutions within its boundaries that were responsible for its welfare. Likewise, uniformist assumptions that the residents could be understood as homogeneous and as having shared common sentiments and values were prevalent in early community studies. Some residents perpetuated the myth of unity and cohesion (Schwartz 1981; Suttles 1972). Even when there were differences, it was assumed that consensus was obtainable among community members.

In more recent studies anthropologists have rejected uniformist assumptions and describe the diversity within the community (Florence et al. 1994; Valentine 1978). Community researchers acknowledge that there are communities within communities (Kingsley et al. 1997; Mattessich and Monsey 1992; Mattessich et al. 1997; Warren 1978). Yet, assumptions about shared values and needs are still prevalent in community health research. According to Schwartz (1981:314), it is assumed that felt needs are shared – even uniformly shared – by the members of a community, as are the values and attitudes on which they rest.

Some believe that the community can solve its own problems (Greenwood and Levin 1998). Yet, many of the problems that communities face are simply not solvable at that level, but are problems of the larger society of which the community is a part

(Warren 1978). Therefore, many obstacles to change in behavior are not located within the community (Schwartz 1981).

Community Studies As Method

Historically considered, community study can be said to have first emerged as a separate and recognized method within anthropology (Arensberg 1954: 109). Yet, others disagree that it is a separate and recognized method. According to Vidich et al. (1964) in studying the community, students have employed other research methods so that community studies themselves have been methodologically eclectic.

There are several methodological issues in community studies. Critics have said that community studies lack a problem orientation and are too descriptive. Furthermore, many question the extent to which a community study can be generalized to other communities in the region or in the larger society. Community studies are generally viewed as limited by the extent of their representativeness (Stein 1960).

Additional methodological weaknesses have been identified in the community study method as a scientific mode of investigation. Vidich et al. (1964) have noted the following caveats: (1) The community portrait may rest primarily on the observations of a single person. (2) Procedures of observation tend not to be routinely systematized. (3) There is no simple guarantee that another investigator would or could produce similar results. (4) The values of the observer may not be disentangled from his/her data. (5) There is no absolute way of knowing if the work is scientifically valid.

The Community Coalition Study Approach

The research study at hand examines the coalition model as the analytical framework for the study of community organization. The literature on coalitions has it origins in political science (Adrian and Press 1968; Kegler 1995). There are different

types of coalitions with various organizational structures (Adrian and Press 1968; Black 1983; Butterfoss et al. 1993). For example, there are statewide coalitions and agency-based only coalitions. Given the nature of the research endeavor at hand, this review focuses only on the community coalition literature.

In academic literature, there are many definitions for community coalitions (Bailey 1992; Butterfoss et al. 1993; Fawcett et al. 1997; Florin et al. 1993; Francisco et al. 1993; Nezlek and Galano 1993; Wandersman 1999). According to Butterfoss et al. (1993:316), the word 'coalition' itself is derived from two Latin roots, coalescere, 'to grow together,' and coalitio, 'a union." In general, a community coalition is an organization that is comprised of representatives of different sectors, organizations, or constituencies who identify with a particular community to combine their resources to effect a specific change that members are unable to bring about independently (Bailey 1992; Fawcett et al. 1997; Francisco et al. 1993; Wandersman et al. 1996; Wandersman 1999).

Members of successful coalitions are presumed to experience coalescence (Blum and Ragab 1985). Coalescence is a process where members shift from only advocating on behalf of their primary member organization to advocating on behalf of the goals and objectives of the community coalition. Blum and Ragab (1985) in their years of monitoring neighborhood organizations classify coalescence as a developmental stage.

The community coalition serves as a model in community organization. Generally, community coalitions are community-directed (Wandersman 1999:6). The community approach uses a coalition as an intervention strategy to address a public health issue such as teen pregnancy. This is recommended by social scientists as a means to increase citizen participation and community ownership of programming (Nezlek and Galano

1993). Community ownership of programming, particularly among disenfranchised high-risk groups that often are not reached by earlier prevention approaches is advocated through community coalition approach (Florin et al. 1993).

Advantages of Community Coalitions

Many federal, state, and private foundation initiatives that address public health concerns about teen pregnancy, tobacco, HIV/AIDS, and pre/post natal care, require communities to have already formed coalitions in order to receive funding. The use of coalitions has become a dominant strategy in community health promotion (Kegler et al. 1998). A number of coalitions have had significant impact on public health indicators including substance abuse prevention, immunization, arson prevention, and adolescent pregnancy prevention (Wandersman 1999:7). Both the academic and the practitioner-oriented literatures cite many advantages of using community coalitions as strategies for developing and implementing public health intervention plans.

Butterfoss et al. (1993) and Kegler et al. (1998) identify potential advantages of community coalitions: (1) Coalitions enable organizations to become involved in issues without having to assume sole responsibility for managing or developing those issues. (2) Coalitions can demonstrate and develop widespread public support for issues and unmet needs. (3) Coalitions tend to maximize the power of individuals and groups through joint action by achieving objectives unobtainable by one individual or organization.

(4) Coalitions can minimize duplication of effort and services. (5) Economy of scale increases trust and communication among the several organizations within a given coalition. (6) Coalitions can mobilize more talents, resources, and approaches to influence an issue than any single organization could achieve alone. (7) Coalitions can provide an avenue for recruiting participants from diverse constituencies, such as

political, business, human service, social and religious groups as well as less organized groups and individuals. (8) The flexible nature of coalitions is thought to allow them to exploit new resources in changing situations.

Disadvantages of Community Coalitions

The coalition model is complex and difficult to implement. The literature is unclear about its effectiveness as a health intervention strategy (Butterfoss et al. 1993; Fawcett et al. 1997; Florin et al. 1993; Francisco et al. 1993; Goodman and Wandersman 1994). Despite the popular appeal of community coalitions, there are many disadvantages to using coalitions as a model in community organization.

Organizations that join coalitions have different ideologies, resources and maintenance needs (Butterfoss et al. 1993:318). Many coalition members have their primary organizational allegiance to another organization, and due to competing interests may not always advocate on the behalf of the coalition. Nelzek and Galano (1993) found in their investigation of adolescent pregnancy prevention coalitions that single-issue participants seemed to be more interested in furthering a specific position or strategy than in furthering the goals of the coalition.

Coalitions, especially newly formed coalitions, expend a great deal of time trying to coalesce member organizations to work together. Nelzek and Galano (1993:442) noted that as coalitions moved from the easy agreement that typically accompanied the broad and vague initial goals to more delineated positions concerning specific issues, disagreements were inevitable. Other disadvantages identified by Nelzek and Galano (1993:442) in their study of adolescent pregnancy prevention coalitions were: (1) Insufficient resources (e.g., unanticipated budgetary "draw-downs") remained a problem. (2) At some point during their development virtually all of the coalitions depended upon

the energy and vision of a single person. (3) It was difficult to find new leadership to replace the founders. (4) Virtually all coalitions reported problems with burnout and frustration. (5) Coalitions reported problems in recruiting and preparing new personnel.

Adrian and Press (1968) note that in any type of coalition formation, potential members must consider the decision cost of participating. Decisions must be made regarding costs associated with information, opportunity and time. The communication of information is complicated by the blurring effect resulting from each individual's imperfect perception of reality and by the screening of all communications through one's personal value system (Adrian and Press 1968:557). Involvement in a coalition may cost members an opportunity to participate in other activities (e.g. pursue funding opportunities on their own without the collaboration of the coalition). Time costs increase as coalition members' participation increases in the coalition.

Proponents of community coalitions tend to oversell the benefits and underestimate the resources needed to support coalition building and intervention development. The capacities needed by communities to implement the coalition approach vary with the contextual factors of each community (e.g. history of collaboration, funding sources). Furthermore, intervention programs that are developed and implemented may not be transferable to different sites within the same community (Scheirer 1994).

Assumptions of Community Coalitions

In order to understand community coalitions as a model of community organizing, it is important to examine the underlying assumptions. Part of the underlying philosophy of the community approach is that targeting multiple systems (youth, families, schools, work places, media) and using multiple strategies (providing information, enhancing

social competencies, promoting alternatives, influencing norms and social policies) will create a synergistic effect on the whole community (Florin et al. 1993:428).

It is assumed that community coalitions are community-wide if various sectors of the community are invited to participate. However, the social boundaries that do exist in every community may prohibit full participation by minority groups and those of lower socioeconomic status. Furthermore, a key operational issue arises: are the constituencies representing organizations willing to shift from traditional to participatory models of participation (Bailey 1992; Florida Tobacco Control Clearinghouse 1999)? It is assumed optimistically in community coalition literature that disenfranchised high-risk groups are able to participate in similar domains of program planning with service providers. The differences in values held by high-risk groups and service providers are solidified by geographic boundaries within the community that inhibit meaningful interaction.

There is an assumption that coalition members tend to be altruistic and do not expect to gain personally and/or, professionally from their participation in community coalitions (Bodo et al. 1991). Mizrahi (1999) notes however, that coalition success is based on reciprocity. Basically, reciprocity is a balanced (over the long-term) social and/or economic exchange between two or more parties (Chagnon 1992; Sahlins 1972; Stack 1974; Williams 1995). According to Mizrahi (1999:6), for participants, it is about "what can I get out of it and what am I willing to put in? For collaboration leaders or initiators, it is about "what can the collaboration obtain from its members and what can they give to collaboration participants to sustain their commitment and contributions?"

Another major assumption about community coalitions is that consensus can be and must be achieved. According to Becker and Dluhy (1998), consensus is not likely to be

achieved either quickly or easily because organizations and communities are internally different and the interests of subgroups differ.

Another prevailing assumption is that community coalitions can solve problems that affect their community, although the problems are embedded in the larger society. Suttles (1972:50) states that those who argue for strong local community control are propelled by the assumption that the local community grows from the ground up, that it is self-generating and potentially self-governing. This may well not be so in many cases. According to Warren (1978), the power situation surrounding a particular community decision is believed to be influenced by the organizational activities of diverse and usually autonomous citizens' groups.

It is assumed that a community approach to intervention development will produce comprehensive programs that address the multiple risk factors at the individual and broader environmental levels (Florin et al. 1993). Likewise, it is frequently assumed that attitudes, values, and personality traits are such important determinants of behavior that changes in the former necessarily precede change in the latter (Schwartz 1981:314).

The Community Coalition Development Model

The process of developing and implementing a coalition is complex (Wandersman 1999:10). Given the strengths, weaknesses, and assumptions about community coalitions, there is much to learn about the stages or phases in the process of coalition development. A central question regarding coalitions in public health is what is known about coalition stages (Butterfoss et al. 1993:328).

According to Butterfoss et al. (1993), coalitions form and develop in specific stages. Coalitions are considered to be evolving entities, and different tasks may be more or less salient at different stages (Florin et al. 1993:418). Activities in each stage may

overlap, occur out of sequence, and/or revert to a previous stage (Florin et al. 1993; Scheirer 1994).

There are several distinct coalition development models in the health education literature. The names of the different stages vary along with the associated tasks. One model advocated by Butterfoss et al. (1993) includes four phases of coalition development: (1) formation, (2) implementation, (3) maintenance, and (4) accomplishment of goals and outcomes. Fawcett et al. (1997:814) uses another coalition development model in evaluating community coalitions for the prevention of substance abuse. According to Fawcett, there are four essential phases: (1) planning, (2) intervention, (3) changes in the community that reduce risk and enhance protective factors, and (4) changes in intermediate and ultimate outcomes.

The coalition development model selected for this research study as the template for assembling and organizing data is the model proposed by Florin et al. (1993). It serves as a kind of "gold standard" of essential steps or tasks necessary to accomplish the stated objective. Florin et al. (1993) take a developmental approach in identifying training and technical assistance needs for 35 community coalitions organized for alcohol and other drug abuse prevention. Florin et al. (1993:419) outlines seven stages of coalition development in their model: (1) initial mobilization, (2) establishing organizational structure, (3) building capacity for action, (4) planning for action, (5) implementation, (6) refinement, and (7) institutionalization. For examples of tasks associated with each stage, see Table 1-1. Florin et al. (1993:418) recognize that these tasks do not constitute an invariant developmental sequence. However, the authors found

it heuristically useful to organize data for assessing progress and technical assistance needs in a loosely chronological framework.

This model of coalition formation has been chosen for this research for several reasons. First, the model is not overly complex, and its utility for organizing and interpreting the action flow of a coalition seemed practical. Second, the model provides a conceptual framework for data collection and analyses. Third, the model focuses only on the coalition process and not on a coalition partnership. Fourth, the model does not dictate interrelationships of a coalition with other entities. Fifth, the model is open-ended enough to deal with the complexity of a newly created coalition. Sixth, the model seemed to be modifiable in some of its detail on the basis of the kind of data generated by the study at hand.

Table 1-1. Stages and Tasks of Coalition Development

Stages of coalition development	Examples of tasks associated with each stage
Initial mobilization	Recruit critical mass of active participants. Engage key community constituencies or sectors
Establishing organizational structure	Establish structure for working group that clarifies roles and procedures. Adequately address both tasks and maintenance functions of the group.
Building capacity for action	Member level capacity: orient members to concepts and provide skill building. Organizational level capacity: establish inter-organizational linkages with other important players in the community.
Planning for action	Assess needs as perceived by community constituencies; prioritize and clearly state coalition goals and objectives. Select an array of intervention strategies based upon literature about program effectiveness.
Implementation	Develop a sequential work plan that sets timelines, allocates resources and assigns responsibilities. Implement activities in a manner that involves key organizational players, networks and broad citizen participation.
Refinement	Use evaluation data for specific program refinements that incorporate community reactions. Identify gaps in programming and add strategies that build toward a comprehensive and coordinated array of programming strategies across community sectors.
Institutionalization	Member level institutionalization: processes for leader succession and recruitment of new members. Organizational level institutionalization: integrate functions into ongoing missions of existing organizations.

Source: Florin, Mitchell, and Stevenson (1993:419)

CHAPTER 3
FIELD EXPERIENCE

In this chapter, I have selected significant events that occurred during my first twelve months of fieldwork. Although, I collected a total of 47 months worth of field data and program documents, this dissertation chronicles in detail only the first ten months of the Centers for Disease Control (CDC) funded program in Jacksonville, Florida. I describe in some detail my personal fieldwork experiences during the initial 12 months as the on-site anthropologist participant observer and participant in the program.

The six topics that I address are: 1) why I was hired by the Duval County Health Department (DCHD), 2) what were my initial perceptions, 3) what were my personal perceptions of DCHD's seeming insensitivity towards the targeted service areas, 4) what were some of the diversity issues (e.g., differences in ethnicity) at DCHD, 5) what were the changes in my job position at DCHD and, 6) why I tended to feel as though I was both an insider and an outsider of the Jacksonville program. I selected these six topics because they give insight on how residency, ethnicity, and gender played a key part in how I obtained field placement, and what kinds of data I was able to collect. Before I go on to describe my field experiences, it is relevant to give both the geographic and demographic characteristics of Jacksonville as well as to describe the field location.

The Geographic and Demographic Characteristics of Jacksonville

Jacksonville is a metropolitan city located in northeast Florida near the Atlantic coastline. In 1967, Jacksonville and Duval County consolidated city and county governments. Thus, in Jacksonville, the city and the county are the same. The area of

Duval County is 840 square miles. See Figure 3-1. The population of Jacksonville continues to increase as individuals, military, and businesses migrate to the area. The 1990 Census recorded 672,971 residents with a median age of 31.5 years. Banking, health care, insurance, and shipping are some of the largest industries. Jacksonville

Figure 3-1. Map of Florida

has one of the largest ports in the United States. It is easily accessible by plane, train, and by car. Interstate 95 and U.S. 1 run north and south through Jacksonville. Interstate 10 commences in Jacksonville and runs east to west through Jacksonville. See Figure 3-2.

Residents and visitors enjoy subtropical weather with mild winters and hot summers. Less than an hour away from the city center are the incorporated beach communities of Jacksonville Beach, Atlantic Beach, and Neptune Beach. Not including

the neighboring beaches, Jacksonville is divided into major areas: Northside, Arlington, Southside, Mandarin, Ortega, Riverside/Avondale, San Jose/San Marco, Springfield, Westside, and downtown. Within these ten general areas are numerous communities and neighborhoods.

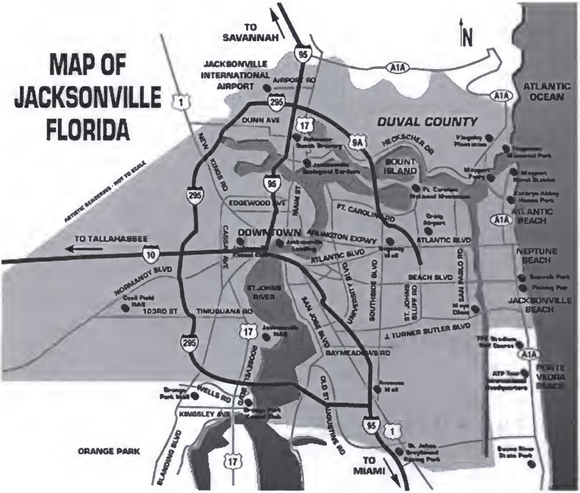

Figure 3-2. Map of Jacksonville, Florida.

Site Locations

DCHD is located within Jacksonville's urban core, i.e., "downtown" Jacksonville. See Figure 3-2. The main building for administration and public records (e.g., birth certificates) along with the adjacent building for the Women's Center dedicated to maternal and child healthcare are located at 515 West Sixth Street. The administrative

main building and the adjacent parking lot are located in the historic community of Springfield. Springfield is one of Jacksonville's oldest communities and is just north of downtown Jacksonville. Springfield is located in zip code 32206, one of the eight zip codes of the targeted areas designated in DCHD's grant application. Throughout Jacksonville, there are 17 DCHD public health clinics.

Evidence of decline around the main building of the health department is apparent. The eastside of DCHD faces some deteriorated and abandoned homes designed in Queen Anne, Prairie-style, and Colonial Revival styles. Due to drug activity and related crimes, Springfield has received unfavorable media attention.

Given its architectural heritage, Springfield was listed in the National Register of Historic Places in 1987. The area became protected from demolition. Renovations have been spurred by initiatives (e.g., below market loans, federal dollars, tax abatements) for urban renewal.

The north, south, and west perimeters of the health department are immediately enclosed by a parking lot. This area encompasses a city block. During business hours, a security guard watches the cars in the lot. Both the public and DCHD employees have access to free parking. Another security guard monitors guests and employees as they enter the main building.

Project staff offices for the teen pregnancy grant were located in the main administrative building. Many of the committee meetings for the community coalition were held in the building's conference room.

In addition to DCHD's main building and clinics, DCHD rents office space five miles away in the "900 Building." This is a commercial building located at 900

University Avenue. Office space for administrative functions (e.g., environmental permits) of DCHD's are located on several floors. The building is located next to the Matthews Bridge, in an area of the city called Arlington. This bridge connects Arlington to downtown Jacksonville across the St. Johns River. Both commercial and residential buildings surround the 900 Building and its adjacent parking lot. There is free parking and there is no security guard. The 900 Building is not in the targeted area of the CDC grant.

Why I Was Hired By DCHD

On December 4, 1995, I was contacted by an anthropologist who had recently been hired by DCHD to conduct an ethnographic study of adolescents in Duval County. The anthropologist explained to me that she had received my name from two anthropologists at the University of Florida. She told me that she needed someone to help her collect data for an ethnography about what it was like to grow up as an adolescent in Duval County. Since her permanent residence was in the southwest of the United States (her husband was on sabbatical and they were staying one hour outside of Jacksonville), and she was new to the area, and hence had no immediate direct contacts with adolescents, she explained that she did not believe she could get the necessary data within the eight months allotted to her by the DCHD. Likewise, she told me that as a white female she was concerned about whether she would be able to get proper access to teens in the African-American community.

Later that day I met with the anthropologist, project coordinator, and grant manager for the teen pregnancy grant at DCHD. I was hired part-time as the "Community Specialist." I learned that for my overall work assignment I would be responsible for identifying groups of teens within the African-American community, to conduct focus

groups, and to conduct interviews with adults who worked with teens. My graduate training in anthropology at the University of Florida, my ethnicity as an African-American, my gender as a woman, and my residence in one of the targeted zip code areas were all factors that seemed to qualify me for the position.

The anthropologist told me that when she joined the project she pointed out to the DCHD director, and staff of the teen pregnancy grant, that there was no ethnic representation on the project staff that reflected the targeted areas. She stated that the director did not see any problem with this. I was the only African-American on the staff.

Initial Perceptions

On January 3, 1996, the DCHD staff for the teen pregnancy program, hereafter referred to as the "project," had its first staff meeting. The grant manager (i.e., money manager) and the project coordinator explained to the staff that a community coalition was going to be formed in order to satisfy the requirements of a grant. The First Coast Adolescent Health Consortium (FCAHC) was the community coalition in DCHD's application designated as Jacksonville's community coalition to address teen pregnancy prevention. However, FCAHC, consisting of health, medical, and social service organizations had become defunct.

The new community coalition would have a diverse membership. CDC wanted input from various sectors of the community (e.g., health professionals, clergy, educators, media) to assist in developing interventions to reduce teen pregnancy. The project coordinator explained that the CDC would be monitoring Jacksonville's progress along with the other twelve participating CDC funded cities. CDC planned to use the information collected by the 13 communities to develop best practices in helping other communities address teen pregnancy issues.

I had visions that I was a part of a federally funded program that would not only change Jacksonville, but could change the national landscape! I felt as though I had become part of a big social experiment that would serve as the catalyst for social change and reduce teen pregnancy.

Since I was already working part-time on the grant doing the teen ethnography with the visiting anthropologist, choosing to study the community coalition process seemed like a suitable topic for my doctoral fieldwork. The director of the DCHD suggested that I consider the health department for my doctoral field study. I decided to observe and collect as much information as I could about the project, the CDC, and the community coalition.

In theory, incorporating different sectors (e.g., social service, business, civic, government/law) of the community to work on reducing teen pregnancy sounded like a great idea. I did not know what to expect when this concept would be put into practice. The official "birth" of the community coalition named as the Jacksonville Alliance for the Prevention of Teen Pregnancy (Jacksonville Alliance) by the staff, occurred so quickly, I was curious to discover what would happen over time.

Personal Perceptions of DCHD's Insensitivity Towards The Targeted Service Areas

I was officially hired by DCHD on January 8, 1996. There were distinct differences between the ethnicity and class of the staff and the targeted community (i.e., targeted zip codes), which the grant was targeted to serve. On January 10, 1996, I joined the just formed project staff (i.e., the grant manager, project coordinator, and anthropologist) on a tour of the targeted zip codes where teen birth rates were the highest. I was excited about the opportunity to see some of the targeted areas. Although I had lived in Jacksonville for seven years, there were many areas that I was not familiar with.

We all boarded the grant manager's mini-van and she gave us a tour. While driving, the grant manager pointed out the depressed areas that made up different neighborhoods within the various targeted zip code areas. She constantly pointed at housing referring to them as "shacks." "Look at that shack, and look at that shack." Finally, after twenty minutes of hearing her identify housing in this manner, I blurted out: "please do not call these houses shacks! If these houses are shacks, then I live in a shack!" I stated that although we did not know the circumstances, it probably, took many years for some people to buy such housing. Indeed, some of the houses could perhaps be categorized as "shacks." However, many of the houses that she had designated as such were structurally sound, modest homes.

I was much taken aback by the apparent insensitivity of the grant manager. I felt her constant repetition of the phrase "look at that shack" was mean-spirited and dehumanizing. I did not feel comfortable riding around pointing out all of the "poor" housing structures. Her attitude and tone of voice seemed to me elitist and condescending. No one said anything immediately after my comments.

As the tour continued, I soon learned that the grant manager remained negative in her outlook on the targeted areas. Thus, 15 minutes later, as we drove by a visibly African-American middle class area with large brick and concrete block homes with manicured lawns, the grant manager exclaimed again: "Shacks, look at these shacks!"

Diversity Issues at DCHD

On January 17, 1996 the grant manager resigned due to family obligations. She agreed to be a project volunteer. During January and February 1996, additional project staff were hired. The new hires included a research assistant, clerk typist, evaluator (i.e., "lead" or head evaluator), and a grant manager/evaluator consultant. The director of

DCHD hired a local pediatrician to serve as the project's principal investigator. Except for the evaluator and the grant manager/evaluator consultant (two part-time positions filled by the same person), all project staff worked part-time.

In a staff meeting in February 1996, the director of the health department proudly proclaimed, "Now we have a multi-colored staff! We have five white women, two white men, two African American women, and one Latino. No one can accuse us of not having diversity!" He laughed and smiled. I noticed that no one else laughed or smiled.

Although there was diversity among project staff in terms of ethnic representation, this did not mean that diversity among the staff would be valued. On March 21, 1996, as I was leaving the second general coalition meeting, I was approached by a coalition member. She was a representative from a participating service organization. I did not know this person, but she said that she wanted me to know that the project coordinator had expressed her dislike of working with the new grant manager, the clerk typist, and myself.

The coalition member stated that she thought it seemed curious that all of the individuals that the project coordinator had a hard time working with were minorities. I was shocked. I had no idea that the project coordinator had been spreading negative ideas about other staff including me to other people outside DCHD. I thanked her for the unsolicited information, and went home.

Later in April, I learned that the project coordinator had told other DCHD staff members, about her discontent in working with the clerk typist, grant manager, and me. If it were not for individuals commenting about the project coordinator's comments I would have never known about her dislike in working with minority staff.

Several months later, in June, the project evaluator came into the office for teen pregnancy. I was sitting at my desk. Without any comment, he came to my desk with a rubber band in his hand, and slung it at me. The rubber band hit my left ear. He turned around and walked out of the office. I did not know what provoked his behavior.

I immediately reported the incident to the new, African American male grant manager/evaluator consultant (the previous African American woman grant manager/evaluator was forced to resign in April). I described the incident and he said he would look into it. Days later, as I was walking to the teen pregnancy office, the evaluator apologized to me in the hallway. He said that he did not mean to vent his anger on me.

A month later, in July, the grant manager/evaluator consultant, lead evaluator, and I were in an evaluators' meeting. The grant manager/evaluator consultant and the lead evaluator got into a heated discussion. The lead evaluator got upset that the grant manager/evaluator consultant was not agreeing with him. He blurted out "listen boy." I was terrified. The grant manager/evaluator consultant did not say anything. The lead evaluator realized what he had said and mumbled an apology.

By the end of July, I began to feel depressed and my initial enthusiasm for the project and the coalition began to wane. I was glad that I was only working part time. I decided to seek the advice of my former committee chair at the University of Florida. I was not sure if this project was going to work out for my doctoral research. I informed my chair about the racial tensions and the lack of input from the targeted community. He told me that as a graduate student, I needed the money, and that I should keep quiet.

After meeting with my former chair, I began to feel more depressed. I grew up in New York City, which is known for its ethnic diversity. People lived in their ethnic enclaves, and when clashes occurred, minorities were overt with their discontent. I grew up as a minority in an Italian neighborhood in the North Bronx. Since elementary school, I was used to disparaging racial remarks, but I was used to fighting back verbally. As an adult, these experiences in Jacksonville were painful. Keeping silent was even more difficult. I reminded myself that I was in the South. I made up my mind to be silent.

A Change In Job Roles: From Community Specialist To Process Evaluator

In the beginning of May, the ethnographic research study was near completion. I asked the project coordinator if community outreach efforts were going to be implemented. She indicated that there were no future plans for community outreach. She explained that individuals and organizations from different community sectors (e.g. health/medical, government/law, education, social services) had been invited to participate in the coalition. She stated that community outreach was completed after the coalition was formed.

At this juncture, I realized that I had a different perception of community outreach. The project coordinator believed that when different individuals and organizations were invited to participate in the Jacksonville Alliance, community outreach had been achieved. She believed that the people on the community coalition represented the community. I thought community outreach would also include making the residents in the targeted zip codes aware of the Jacksonville Alliance, and soliciting their input into how to reduce teen birth rates in the targeted areas. I realized then that in my position as a Community Specialist, my future involvement with the grant would be limited since there were no projected outreach efforts in the targeted zip codes.

One day in May 1996, I stopped by the director's office of DCHD. The director of the DCHD was now serving as principal investigator and grant manager of the teen pregnancy project since the principal investigator and the second grant manager/evaluator consultant had resigned in April. I explained that I had read the grant and that a process evaluation was required. I indicated that the evaluator was focusing on program evaluation, and that I was able to do the process evaluation given my academic training in anthropology. He suggested that I set an appointment to meet with him to discuss this further.

I told the principal investigator that I had spoken with a woman researcher and expert on consortia/community coalitions, and that I started reading some articles. I did know that he knew this expert when I contacted her. He was impressed that I had spoken with this expert and eagerly set a date on May 31, 1996 to discuss the possibility of me conducting the process evaluation.

The DCHD director decided that in my new role as the process evaluator, my responsibility would be to document the processes that were occurring in the coalition. Likewise, I would be responsible for collecting data regarding the community coalition (e.g., coalition member survey, project administration forms) that would be submitted to the CDC for their cross-site evaluation study.

During this meeting with the DCHD director, I reminded him that I wanted to use the grant project with the focus on the community coalition as my fieldwork for my doctoral research. The DCHD director as principal investigator gave his approval. He said that he would call my dissertation committee chair in Gainesville. Likewise, he told the evaluator to set up an appointment with my chair to discuss any necessary details.

On June 28, 1996, the evaluator and I met with the former chair of my committee at the University of Florida. The evaluator explained my new role as process evaluator and that the principal investigator had agreed to allow me to use the project for research. My former chair mentioned that he had already spoken to the DCHD director. The meeting in Gainesville seemed to have gone well. I was thrilled that my new position would facilitate my doctoral research.

Participant Observer: Being Both An Insider And Outsider

In doing ethnographic fieldwork as a participant observer, I found myself oscillating between degrees of being an insider and an outsider of DCHD, project staff, and coalition meetings. As a staff person, it was easy at times to act as a full participant observer without observing as an outsider. It was easy for me to become intensely involved in discussions during staff meetings or participate in committee meetings for the community coalition.

At general community coalition meetings, I always took on the outsider role. The size of the conference room at the downtown campus of the Florida Community College Jacksonville (FCCJ), and the large number of individuals who attended the general meetings made it relatively easy for me to become a nearly invisible detached observer. Moreover, as the process evaluator at the general community coalition meetings, I did not have a visible and high profile role like the project coordinator or grant manager. Coalition members did not ask me questions at these meetings.

Furthermore, my training as an anthropologist, as well as my African-American background facilitated my switch to the outsider role. Likewise, when I attended off-field site meetings such as the CDC Technical Assistance Workshop meeting, it was easy

for me function as a mere observer 'outsider.' There were no expectations in these settings to act as a full participant.

Over time, I had to balance the roles of insider and outsider. As a staff person, unlike most coalition members, I was able to participate and observe the "inner workings" and the "behind the scenes" of the community coalition and the hub organization (i.e., DCHD). I would not have gained this type of insight if I had just attended general coalition meetings or committee meetings.

I found it challenging to do ethnographic fieldwork in the town where I had lived. I was aware that if any negative community relations occurred between project staff, Jacksonville Alliance, and the targeted zip codes, my involvement with the project could have resulted in unpleasant consequences for me since I lived in one of the targeted zip codes. All other project staff lived far away from the targeted zip codes in Duval County; some staff lived in the neighboring counties of Clay, St. Johns, and Flagler.

Summary

My field experiences of studying a community coalition as a staff person of DCHD were very challenging and often difficult to navigate. I was hired by DCHD to work on the teen pregnancy grant because of my graduate training in anthropology and to bring diversity to staff as an African-American woman. Given my experiences at DCHD, I soon learned how different I was from other staff. Diversity does not guarantee acceptance of different viewpoints. I was not part of the "in" group at DCHD. I was not privy to all information within the social-professional networks of DCHD.

In retrospect, I must have seemed very naïve when asking questions about community outreach, and by assuming and expecting that staff would be overtly sensitive to the targeted areas. I thought that teen pregnancy would be addressed by a collective

effort by everyone in the Jacksonville community. I assumed by my initial position as community specialist that the DCHD would embrace a grassroots orientation. My next appointment to the process evaluator position facilitated my ethnographic research in studying coalition formation as I oscillated between being on the inside or outside of these groups.

CHAPTER 4
DATA GENERATION METHODOLOGY: AN OVERVIEW OF TECHNIQUE AND PROCEDURE

This chapter describes three research processes for my study on the initial organizational life course of a community coalition. First, I identify the methods used for the study. Second, I describe the techniques I used for data collection and data recording. Third, I outline the analytical process to which I subjected the data.

Methods

Two methods were used for this research study: 1) the ethnographic method, and 2) the community study method. The latter also includes the collection of formal organizational documents and records. Both methods complement each other by facilitating the collection of qualitatively driven data. Each method lends itself to a description of the community coalition development processes.

Ethnographic Method

Although ethnography has its roots in anthropology, ethnography is now used by many disciplines (Camino 1997; Creswell 1994; Creswell 1998; Germain 1993). Moreover, ethnography is increasingly used in evaluation (Camino 1997). According to Camino (1997), there are both anthropological and non-anthropological kinds of ethnography. The many varieties of ethnography make a singular definition impossible (Germain 1993: 237).

According to the anthropologist James Spradley (1980:3) ethnography is the work of describing a culture. The central aim of ethnography is to understand another way of

life from the native point of view. Generally, ethnography is description, analysis, and interpretation of a cultural or social group or system (Camino 1997; Creswell 1997; Wolcott 1999).

Given the type of my research questions, I wanted my research study to be primarily qualitatively based. I selected the ethnographic method for this research study because I wanted to understand the early organizational life course of a community coalition. In order to understand, it is first necessary to describe. The central task of the ethnographic method is description of a cultural or social group. The product, the ethnography, is an in-depth understanding of the fluid organizational life course of the community coalition.

The ethnographic method involves participant observation. Participant observation is the anthropological method used to gather information by living and working as closely as possible to the people whose culture is under study (Spradley 1980). Participant observation was a primary method for obtaining data on the organizational life course of the Jacksonville Alliance.

Community Study Method

I selected the community study approach as a complementary method to understand the teen pregnancy prevention community coalition that was formed in Jacksonville. The community study method involves first hand investigation usually through participant observation. Community researchers have been particularly conscious that everything they do in the field, the preparation for entering the field, the process of analyzing the data, the intellectual conversations with others, and the reporting of the study itself are all part of the methodology of the study. . . . (Vidich et al. 1964).

I learned that I could not study everything. My job was to establish the priorities of relevance (Arensberg 1954). According to Vidich et al. (1964:vii), no one has yet been able to present a formal methodology for the optimum or proper method for the scientific study of the community. This is necessarily so because there is no way to completely disentangle the research method from the investigator himself.

Conversations with others were an important technique for gathering data in my community study. These discussions were useful for viewing the formation of a community coalition within the general context of community organization. In using the community study method, I viewed the community coalition as representative of the Jacksonville, Florida community and as a part of the larger Jacksonville community.

I entered the field with research questions shaped by the coalition development model of Florin et al. (1993). My research questions were formed accordingly. Throughout my field experience, my research work was furthered by frequent intellectual conversations with members of my doctoral committee.

All of these conversations helped me to clarify what data I 'wanted' to collect compared to the data that I 'would' be able to collect as a single researcher. Initially, I had research aspirations that required a team of community researchers. As time progressed, I was able to narrow the scope of my community study and to focus on examining the first four stages of the coalition development of the Jacksonville Alliance. This process of moving from a macro-study to a micro-study proved to be a taxing experience.

Data Collection and Data Recording

Ethnographic research is conducted in a so-called natural setting. Given the anthropological nature of my work, my formal start of fieldwork may be said to have

begun on December 4, 1995 when the Duval County Health Department (DCHD) in Jacksonville, Florida first contacted me. During four years of fieldwork from December 1995 to October 1999, my base of operations was the DCHD. This ethnographic research study focuses on the first ten months of fieldwork from December 1995 to September 1996.[1]

Field Notes

I recorded data in my field notes from participant observation and unobtrusive observation. I took field notes at numerous general meetings of the entire coalition body (i.e. general coalition meetings) and committee meetings. See Table 4-1 for types of meetings that I attended and for the data methods that I used. Initially, I was just an observer at the committee meetings for the ten component committees of the Jacksonville Alliance. As time progressed, I became more of a participant observer at some of the committee meetings. My level of participation varied with the committees that I became involved in. For example, I was only a participant observer two percent of the time with the Business/Civic Committee. Yet, I was a participant observer fifty percent of the time with the Religious Community Committee. The number of committee members that were in attendance often influenced my level of direct participation in the proceedings, that is to say, when attendance was high, my participation was low, and vice versa.

I also took field notes as a participant observer at CDC site visits, and at staff meetings of the Teen Pregnancy Program (later renamed Adolescent Pregnancy Prevention Program). I took field notes off-site as I documented activities at the CDC

[1] During my 47 months of fieldwork, as the process evaluator, I distributed a coalition member survey and I conducted semi-structured interviews with key participants in the Jacksonville Alliance.

Technical Assistance Workshop meetings. Through non-participant observation, I took field notes at neighborhood/community meetings.

Table 4-1. Data Collection Methods for Types of Meetings 12/95 – 9/96

Type of Meeting	Number of Meetings	Observation	Participation Observation
General Coalition	5	100%	0%
Executive Committee	4	98%	2%
Media Committee	6	100%	0%
Government Committee	7	60%	40%
Education Committee	7	90%	10%
Business/Civic Committee	5	98%	2%
Social Services Committee	6	100%	0%
Health & Medical Committee	7	100%	0%
Parents and Community Committee	6	70%	30%
Religious Community Committee	7	50%	50%
Staff Meetings	22	0%	100%
CDC Site Visits	1	0%	100%
CDC Technical Assistance Workshops	2	0%	100%

At any type of meeting, I recorded discussions and interactions between the meeting attendees. At every meeting, I collected and logged-in any materials that were distributed. After a meeting, I reviewed my field notes, and added anything from my memory that I recalled from the meeting. I kept a separate three-inch binder for staff meetings, general coalition meetings, committee meetings, and neighborhood/community meetings.

I designed a documentation instrument that I used to log-in data at different types of meetings. This instrument facilitated the recording of basic information such as: name of meeting, date, time started, time ended, location, and individuals in attendance. See Appendix A for additional categories of the documentation instrument. The average

meeting time for a general coalition meeting was one and half to two hours. A committee meeting usually lasted for one to one and half hours. Staff meetings lasted for two to three hours.

Committee Profiles

Having compiled the available and generated data, I compared and combined them with the meeting minutes in order to have a complete documentary record of the general coalition meetings and the committee meetings. As a result, a set of what I have called 'committee profiles' were created for each of the nine committees and for general coalition meetings. A committee profile describes what occurred in each meeting of a particular committee. Each committee profile also contained information about the formation and purpose, initial participating organizations, and areas for consideration by each committee. I organized data in the following format: 1) membership participation and information materials, 2) introduction and review of old business, 3) committee tasks and goals, 4) meeting activity, and 5) housekeeping details. See Appendix B for an example of contents in a committee profile.

Fifty-one committee meetings were documented in the committee profiles. Five meetings were documented into general coalition profiles.

Organizational Records

I collected eight different types of documentation during my fieldwork: 1) coalition meeting schedules and coalition minutes, 2) materials distributed at coalition meetings, 3) materials from organizational members, 4) project staff meeting minutes, 5) memoranda, 6) project documents such as applications and semi-annual reports, 7) materials on adolescent pregnancy, and 8) CDC program documents. I created separate folders and labeled them according to each type of organizational record. Subsequently, my coalition

field notes and the meeting minutes were placed into a binder along with the materials distributed at every coalition meetings. In addition, I put staff meeting minutes in the binder with my field notes of staff meetings. See Appendix C for an itemized listing of the body of data collected in the field.

Data Analysis

Analysis of any kind involves an ordered way of thinking. It refers to the systematic examination of the whole corpus of data to determine its parts, the relationship among parts, and their relationship to the whole. Analysis in this case amounts to a search for patterns (Spradley 1980:85). Customarily, the data analysis involved the comparison and contrast of various data sources. I focused on several major processes during my analysis.

First, I completed a document review of committee profiles and organizational records to identify the various stages of coalition development of the Jacksonville Alliance. Second, I examined my field notes for descriptions of coalition activities that were started and/or completed during each coalition development stage. Third, after I identified coalition stages and tasks associated with each stage of the Jacksonville Alliance, I compared and contrasted the data from the document review and my field notes to the conceptual framework of Florin et al. (1993). Fourth, I compared CDC program documents to the data from the document review and my field notes. I contrasted CDC's expectation to what actually occurred in the coalition development process.

Summary

Holistically speaking, I used two methods in this research study: the ethnographic method and community study method. I recorded data in my field notes as a participant

observer and as a non-participant observer listener. I was a participant observer at numerous coalition meetings, coalition committee meetings, and Adolescent Pregnancy Prevention Program's staff meetings. I was a non-participant observer at neighborhood/community meetings.

The documentation I collected through field notes and meeting minutes were combined to give a complete record of each meeting. Data were put together into 'committee profiles.' Organizational records were collected and categorized.

The data analysis involved comparing and contrasting the conceptual framework of Florin et al. (1993) to the coalition activities of the Jacksonville Alliance. Likewise, a comparison is made from CDC program documents to what actually occurred in the community coalition.

CHAPTER 5
THE JACKSONVILLE ALLIANCE: AN ETHNOGRAPHIC CHRONOLOGY OF THE FIRST YEAR OF A COMMUNITY COALITION PROGRAM FOR TEEN PREGANCY PREVENTION

This chapter chronicles the organizing stages and tasks that occurred during the initial developmental life of the Jacksonville Alliance. The data, gathered via fieldwork observation, interview and documentary evidence are presented within the context of the conceptual model proposed by Florin et al. (1993). This model provides the framework for the acquisition and reporting of pertinent data and for assessing the community coalition formation.

The happenings of the Jacksonville Alliance are sequentially presented over five general coalition meetings from January 30, 1996 through September 25, 1996 and five series (or rounds) of sector committee meetings starting from February 21, 1996 to September 10, 1996. Midway through this chapter, a sampling of documents disseminated at the third general coalition meetings by project staff is available for quick reference by the reader in the Appendices.

Four primary research questions stem from the conceptual model proposed by Florin et al. (1993): 1) How does the community coalition come into existence? 2) How does the community coalition establish its organizational structure? 3) How does the community coalition increase its ability to act? 4) How does the community coalition plan for action?

In this chapter, I answer these questions around the first four stages of coalition development: 1) initial mobilization, 2) establishing organizational structure, 3) building

capacity for action, and 4) planning for action. In essence, the chronology of events is a report on what occurred and what the participant observer-listener learned during the first year of the project from October 1995 to September 1996.

Formal Start-Up Of The Jacksonville Alliance

On October 1, 1995, Jacksonville, Duval County, Florida along with 12 other cities in the United States became participants in the U.S. Centers for Disease Control (CDC) "Community Coalition Partnership Programs for the Prevention of Teen Pregnancy." The CDC awarded the Duval County Health Department (DCHD) approximately $500,000 for two years to support DCHD's efforts as the "hub" (i.e., lead agency) organization to enhance its capacity to strengthen and evaluate the effectiveness of the coalition partnership program in Jacksonville.

On December 13-15, 1995, all awardees of the CDC "Community Coalition Partnership Programs for the Prevention of Teen Pregnancy" attended a technical assistance workshop in Atlanta, Georgia. CDC program staff and representatives from the hub organizations of the 13 CDC funded community coalition partnerships met for the first time. During this CDC workshop, DCHD staff (i.e., known as Teen Pregnancy within DCHD) learned that the CDC required hub organizations to be members of active community coalitions.

Yet, by the time DCHD had submitted its grant application to the CDC, during the summer of 1995, the First Coast Adolescent Health Consortium (FCAHC) had dissolved. In the grant application to the CDC, FCAHC agreed to serve as the community coalition, and the DCHD agreed to serve as the hub organization.

After the December CDC workshop, at the first staff meeting on January 3, 1996, the project staff decided to create a new community coalition. The defunct FCAHC was

comprised of health/medical and social services organizations. DCHD project staff believed that in order to plan interventions to prevent teen pregnancy, input was needed from various sectors of the Jacksonville community.

After brainstorming for possible names of the new community coalition, staff named the community coalition the Jacksonville Alliance for the Prevention of Adolescent Pregnancy, the "Jacksonville Alliance," for short. Staff decided to hold the first meeting of the Jacksonville Alliance on January 30, 1996 at 5:30 p.m. at the downtown campus of Florida Community College Jacksonville (FCCJ). Staff identified open-ended names of individuals and organizations to invite to the first community coalition meeting.

Several days after the first DCHD staff meeting, project staff formally reviewed the list of prospective coalition individuals and organizations and added additional names. Letters of invitation were sent to members of the former FCAHC organizations. The initial list was comprised of educators, clergy, business, government/law, media, and civic organizations. They were asked to attend the first meeting of the Jacksonville Alliance. At this juncture, it is important to note that area residents (e.g., teens and parents) from the prospective "targeted" service areas were not invited to participate in this initial formative step of the community coalition.

The First General Coalition Meeting Of The Jacksonville Alliance

On January 30, 1996, eighty individuals including six DCHD staff attended the first general meeting of the Jacksonville Alliance at FCCJ Urban Resource Center. A careful examination of the attendance roster revealed that participants came primarily from the established sectors of the professional community: Representatives from social services

agencies, business, education, media, government/law, health/medical, and religious community were present.

Staff greeted participants before they entered a large conference room. Everyone received a nametag and an information packet. The information packet contained an agenda, a list of names and titles of project staff, the Jacksonville Alliance Adolescent Pregnancy Overview handout, a list of committee tasks, and descriptions of each committee.

Formative Aspects of the Initial Meeting

The director of the DCHD presented the overview of the prospective Jacksonville Alliance. Everyone at the January 1996 meeting appeared to be attentive as he announced that Jacksonville had received approximately $500,000 from the CDC for two years to be used to address the teen pregnancy problem at a community level. He explained that the money had to be spent during the grant period that the CDC had labeled as "Phase I." Phase I was the planning period (i.e., October 1, 1995 to September 30, 1997) for the DCHD and the time frame for the coalition to develop a community action plan (CAP). Based upon the community action plan, approximately half of the 13 CDC funded community coalitions in the USA were to receive additional funding to implement the CAP during "Phase II." Phase II was to be a five year implementation period from October 1, 1997 to September 30, 2002.

The DCHD director explained that DCHD was both the fiscal agent for the CDC grant and the hub organization of the prospective Jacksonville Alliance. He stated that he needed help from everyone who became a member of this coalition in deciding how to spend the grant dollars in Jacksonville. He told those present that they could gradually proceed to plan intervention initiatives to prevent teen pregnancy for the Jacksonville

community. At this time, however, he did not make it explicit that the CDC required interventions to be planned for the already specified geographic area of the targeted community.[1] "Targeted community" was the term used by the CDC and DCHD in describing a geographic area where teen pregnancy birth rates were identified to be 1.5 higher than the national average. Furthermore, the principal features of the targeted community were not discussed at this initial formative coalition meeting.

The prospective coalition members at the meeting were informed that Jacksonville qualified for the federal grant because of its high teen birth rates in the eight zip code areas that comprise Jacksonville's urban core. In the original DCHD's grant application, the DCHD director clearly promised to target eight zip codes that had the highest birth rates, but added that services and resources developed could apply to the entire Jacksonville community.

An Outline of the Vision for the Prospective Jacksonville Alliance

During the first general meeting, one participant from a social services agency facilitated discussion about the vision of the Jacksonville Alliance. Participants agreed to work towards a broad vision. In the course of the gathering, the following ideas, written on a poster clipboard, were suggested regarding the vision of the Jacksonville Alliance:

- Working with teen fathers/teen males
- Providing access to services for males and females
- Opening all doors of opportunity to all teens within the community, and working to keep the doors opened
- Providing hope and opportunity for youth

[1] See chapter 1 for further details.

- Making 1996 the year of promise and using education and prevention to show promise to teens
- Providing every youth in the community a healthy future and a place to go
- Opportunity for gainful employment and quality education
- Providing early education
- Stressing community involvement
- Building neighborhood involvement
- Encouraging religious community taking a more active role in the lives of youth
- Increasing physician involvement with teens and parents concerning sexuality issues
- Ensuring everyone in community responsible and involved
- Cultural/value sensitivity
- Working with the power structure in Jacksonville to acknowledge the existence of the Alliance and provide the infrastructure to do the work
- Seeking parental involvement
- Creating accessibility to school

DCHD staff informed meeting participants that the staff would incorporate the suggestions into several draft vision statements to be reviewed and ranked in a mail-in ballot by prospective coalition members. Actually, there was no formal membership for the Jacksonville Alliance. Staff maintained a database, or rather, a mailing list of names and addresses of individuals and representatives of organizations who were invited to participate in the Jacksonville Alliance. At no time, during the first year of the community coalition, was membership discussed by the staff or by the members themselves. Accordingly, "attendees," "participants," and "members" are used interchangeably throughout this study.

The Need to Establish Organizational Structure

During the first general coalition meeting, the DCHD director repeated his announcement that the two-year grant required a viable organizational structure for developing a community action demonstration plan about how Jacksonville intended to address the teen pregnancy problem. He said that the plan would be developed from the work of individual committees and the Jacksonville Alliance as a whole.

He informed participants that nine committees were to be formed that evening based on the existing "sectors" of the Jacksonville community. Each individual sector committee was expected to work on designing teen pregnancy reduction interventions to be included in the overall community action plan. The initial constituent Jacksonville Alliance sector committees to be formed were: health/medical, education, media, business/civic, government/law, religious community, teens, parents and community, and social services.

Eventually, the original structure of the Jacksonville Alliance evolved into eleven committees. During the first three months of the coalition's existence, an Executive committee was formed. The Executive committee consisted of committee chairs and the principal investigator of the CDC grant. A Pregnant and Parenting Teens committee was added to the coalition structure in September 1996.

The project coordinator (DCHD staff) emphasized that the committee structure of the Jacksonville Alliance was designed to mobilize all segments (i.e., sectors) of the community to address the problem of teen pregnancy. It was generally assumed that each committee represented a particular community action sector of concern to the Alliance. For instance, the Teens committee was intended to represent the teen segment of the community. It was reasoned that due to the complexity of the phenomenon of teen

pregnancy, input was needed from different sectors of the community to develop strategies to prevent teen pregnancy. The project coordinator referred everyone to the handouts on the descriptions of each committee and the list of committee tasks that were included in the original information packet. At the end of the initial January 30, 1996 meeting, participants had the opportunity to sign-up for any of the initial nine proposed Jacksonville Alliance committees.

The Need to Build Capacity for Action

Building a capacity for action during the first nine months in the life of the Jacksonville Alliance was a continuous process. It did not occur as a separate stage. Given the chronological framework used in this research study, I selected several activities to highlight member and organizational capacity building efforts.

DCHD staff was the official recipient and agent of building capacity for action. Functioning as the liaison to the CDC, DCHD staff was expected to be able to receive guidance to form a community coalition after they attended the first CDC Technical Assistance Workshop held in Atlanta in December 1995.

Project staff disseminated information as a strategy to build the coalition's membership capacity for action for developing interventions in Jacksonville. Project staff distributed literature about teen pregnancy and teen pregnancy prevention efforts at all general coalition meetings in Phase I. At the committee level, members received articles about teen pregnancy prevention that were specific to the committee concerns. For example, the Media committee received articles about the media and teen pregnancy.

DCHD project staff invited national, state, and local experts to speak at the Jacksonville Alliance general meetings to share information about trends in teen pregnancy and to give advice to the entire coalition membership in planning intervention

programs. Members learned about characteristics of programs that worked in other communities. In March 1996, one speaker offered a training workshop to coalition members entitled "Understanding Adolescence."

In June 1996, DCHD program staff returned to Atlanta, for the second CDC Technical Assistance Workshop. Staff exchanged ideas with other CDC funded community coalition representatives about community mobilization, youth development, and national efforts in teen pregnancy prevention.

In July 1996, several members of the Health and Medical committee went to West Palm Beach, Florida to collect information on the operation of "Teen Time" clinics. This trip was intended to enable members of this sector committee to become more able to build their capacity for action while formulating ideas about a teen clinic in Jacksonville. The details of the above indicated a sequence of happenings that will be elucidated later on in the presentation of the specific chronology of events.

The Need to Plan for Action

After the first general meeting of the Jacksonville Alliance, individuals received notification regarding upcoming individual sector committee meetings. These committee meetings were held every six weeks. In this study, all sector committee meetings held within every six weeks have been documented as a "round." The initial meetings that were held by all committees comprise "round one." The second set of meetings of all committees is included under "round two."

From February 1996 through September 1996, all committees spent seven months identifying strengths, barriers, goals, and objectives based upon their community sectors (e.g., health/medical, media, social services). Sector committees took five rounds of meetings to complete these processes. The project coordinator's strategy was to have

each sector committee proceed from the general to the particular in developing teen pregnancy prevention programs.

In order to facilitate this process, the project coordinator had a different "lesson plan" for each round, and each "lesson plan" was applicable for each sector committee. For instance, the first "lesson plan" was to identify strengths in the sector committee area (e.g., education). All of the nine sector committees of the Jacksonville Alliance followed the same meeting process during round one. Using the same "lesson plan" during each round of meetings was intended to ensure that all sector committees were consistent in fulfilling meeting activities (e.g., identifying goals and objectives).

In order to facilitate describing meeting processes for each round, this study selected several sector committees that are representative of meeting activities that occurred during each round. All nine committees had similar maintenance (e.g., reviewing meeting minutes, scheduling dates and times of future meetings) and task (e.g., meeting activity) functions. Hence, different sector committees were highlighted for every round of meetings to illustrate the work in progress overall by the Jacksonville Alliance. Overall, the description of meeting activities during five rounds collectively includes all of the nine sector committees of the Jacksonville Alliance.

Table 5-1 details the attendance of sector committee members and of project staff throughout the full set of sector meeting rounds. As such, Table 5-1 provides an overview of meeting patterns of sector committees for the first five rounds that occurred from February 1996 through September 1996. The numbers in parentheses represent DCHD project staff. The asterisk represents the attendance of the researcher. The researcher attended 42 out of 50 meetings during the first nine months of the Jacksonville

Alliance. At times, the DCHD project staff outnumbered other committee members at sector committee meetings.

Table 5-1. Meeting Attendance

Meeting Type	Round 1 2/21/96-3/6/96	Round 2 4/9-18/96	Round 3 5/15/96-6/7/96	Round 4 6/26/96-7/16/96	Round 5 7/16/96-9/10/96
Social Services	5 (3) *	9 (3) *	8 (4) *	9 (4) *	10 (4)
Education	3 (4) *	5 (2) *	5 (3) *	5 (3) *	7 (3) *
Business/Civic	5 (3) *	5 (2)	7 (3) *	3 (2) *	3 (1)
Media	2 (5) *	3 (1)	7 (3) *	5 (4) *	6 (2) *
Government/Law	3 (3) *	5 (3) *	3 (2)	2 (4) *	5 (2) *
Health & Medical	8 (5) *	9 (2)	8 (2)	8 (5) *	7 (3) *
Teens	9 (5) *	6 (2) *	6 (2)	6 (4) *	10 (3) *
Parents & Community	5 (4) *	3 (2) *	3 (3) *	5 (3) *	4 (3) *
Religious Community	7 (4) *	4 (2) *	3 (3) *	2 (2) *	4 (2) *
General Coalition Meeting	73 (7) * 1/30/96	54 (7) * 3/21/96	53 (6) * 5/1/96	47 (5) * 6/27/96	46 (5) * 9/25/96

Note: The numbers in parentheses represent DCHD project staff. The asterisk represents the researcher.

Salient Events in Round One of Sector Committee Meetings

Salient aspects of sector committee and general Alliance meetings are presented now. Particular sector committees were selected to give examples of what occurred during each round. The first round of committee meetings for the Jacksonville Alliance occurred from February 21, 1996 through March 6, 1996. Each meeting lasted approximately one hour and was tape-recorded. The project coordinator used the same agenda topics for all meetings: introduction, Jacksonville Alliance overview, and committee tasks, overall committee goals and timeframe during Phase I, brainstorming exercise of identifying strengths in Jacksonville, and housekeeping details. The content

covered in the committee meetings was similar except for variations based on community sector interests.

Jacksonville Alliance Overview

The project coordinator guided members through an information packet that was distributed at beginning of each separate committee meeting. All attendees received a packet of information that included: an agenda, a committee roster, and handouts listing the purpose of the nine committees of the Jacksonville Alliance, the areas of special committee chair/facilitator responsibilities, and literature about adolescent pregnancy.

The literature in each committee information packet had commentary literature specific to the committee community sector and general literature about adolescent pregnancy. For example, community sector specific literature included "School-Based And School Linked Health Centers" by Advocates For Youth, "Media Effects on Adolescent Sexuality" by Advocates for Youth, and "Criminal, Family, And Other Support Laws Relating To Teenage Pregnancy" by Charlene Carres. General literature about teen pregnancy, as disseminated at the first round of meetings, included:

- "Adolescent Pregnancy: A Summary of Prevention Strategies," compiled by Amanda Deaver, (1994), published by The Center for Population Options.
- "Adolescent Sexual Behavior, Pregnancy and Parenthood," compiled by Brinton Clark, published by Advocates For Youth.
- "Adolescents Are Not Just Short Adults" by Marion Howard, Ph.D. (undated).

The Alliance project coordinator gave an overview of the CDC project (i.e., grant/Alliance) at each of the nine sector committee meetings. She reiterated what was said at the first general coalition meeting. She explained that the initial grant was a two-year project that would address the problem of adolescent pregnancy and work towards the development of effective prevention strategies. Furthermore, the Jacksonville

Alliance was to develop a community action plan by September 1997 that was to be presented to the CDC. At that time, the Jacksonville Alliance could apply for a continuation grant that included up to five years of implementation funding.

Purpose of Committees

The project coordinator prepared (i.e., by herself) a handout explaining the committees' purpose before the initial meetings. The committee purpose handouts defined the work parameters and a four-item list of key tasks to achieve the purpose for each committee. The purpose of each committee was to be directly related to the community sector that it was representing in the coalition. The project coordinator discussed the purpose of each committee. The purposes of four of the nine sector committees are highlighted here: the Government/Law committee for example, was to "work with law enforcement, legal and legislative leaders to promote the enhancement of health education and adolescent pregnancy prevention programs, and support consistent enforcement of criminal laws in the community which affect teens." The Health & Medical committee was to "examine the problems of inaccessibility and under-utilization of medical and health services by the adolescent population and to generate community support for a clinical services system . . . for adolescents."

The purpose of the Media committee was to "identify effective intervention strategies through public awareness campaigns, public service announcements, which relay messages of delaying parenthood, responsible sexual behavior, male responsibility, and the like." The Business/Civic committee's purpose was to "explore strategies to educate and involve the business/civic community in addressing issues and helping to solve problems associated with adolescent health and school - age pregnancy

prevention." These and the rest of the nine committees and their respective purposes are now summarized in tabular form in Table 5-2.

Sector Committee Tasks For Round One Of Committee Meetings

Following a discussion of committee purposes, the project coordinator asked each committee to complete four standard tasks. (See Table 5-3.) Individual committee members proceeded to review the committee tasks handout. Two major activities were omitted from the standard committee tasks handout. They are: 1) committees were requested to identify strengths in the sector of the community sector that they were representing (e.g., media), and 2) committees were expected to engage independently in several rounds of goal and objectives setting for their committee.

The project coordinator discussed in detail the timeline for accomplishing committee tasks and goals. She emphasized that by February 1997 each committee should have selected three priority intervention projects. This should include an outline of pertinent tasks and their prioritized implementation within the community. It was further emphasized that from February 1997 through July 1997, every committee would proceed to pilot 1-3 projects based on their ability to carry them out, and report their committee's progress for the overall community action plan.

Attendees were told that each committee (e.g., Government/Law, Business/Civic) was to address issues regarding teen pregnancy prevention that were specific to the community sector that the committee was representing (e.g., government, business). Every sector committee chairs was informed that he/she was to submit three progress reports to the CDC. The project coordinator noted that the staff of the Jacksonville Alliance would compile the committees' specific suggestions for the community action

plan. She assured attendees that the staff of the Jacksonville Alliance would be available to assist committee members in accomplishing their goals.

Table 5-2. Purpose of Committees

Committee	Purpose
Business/ Civic	The committee will explore strategies to educate and involve the business/civic community in addressing issues and helping to solve problems associated with adolescent health and school –age pregnancy prevention. By investing in programs offering work exposure, career planning, and training opportunities, youth can be given a future as an alternative to sexual involvement and/or pregnancy.
Parents	The committee will identify what is needed to assist parents in their roles as the primary educators of values that shape children's behavior, especially those involving relationships skills and sexuality. Strong parental involvement is the key factor in determining and reinforcing the moral and ethical framework for adolescent decision- making. Community parents will be recruited by the committee to provide guidance and feedback.
Teens	The committee will recognize teens as the primary source of information for one another, and acknowledge the importance of peers in shaping adolescent behavior – both positively and negatively. Whenever the energies of teens have been tapped, the results have been a remarkable attribute to their capacities. Teens will be recruited as "experts" to direct the committee's work.
Heath &Medical Services	The committee will examine the problems of inaccessibility and under-utilization of medical and health services by the adolescent population, and generate community support for a clinical services system that ensures the availability of quality, community-accepted health care, including pregnancy related services, at locations and times suitable for adolescents.
Social Services	Public and private agencies involved with youth have played strong leadership roles in stimulating interest, operating, and funding programs. The committee will work with youth servicing agencies and organizations to create a system of coordination and collaboration among providers in order to maximize the benefit to the teen population, and reduce duplication and under-utilization of services.
Religious Community	Religious communities provide ideal places where youth learn to make positive choices and learn healthy life styles. The committee will explore ways to unify the religious community across denominations, and gather support for adolescent pregnancy prevention efforts and enhancing communication on these issues.
Media	Media is an extremely important player in pregnancy prevention with an enormous capacity to communicate positive messages to teens. The committee will identify effective intervention strategies through public awareness campaigns, public service announcements, etc. which relay messages of delaying parenthood, responsible sexual behavior, male responsibility, and the like.
Education	The committee will provide assistance to school personnel and expanding pregnancy prevention efforts initiated in the schools. Particular attention will be paid to the existing efforts surrounding sexuality and life skills education curriculum development, and specific training opportunities for educators in areas of sexuality & health education and prevention.
Government/ Law	The committee will work with law enforcement, legal and legislative leaders to promote the enhancement of health education and adolescent pregnancy prevention programs, and support consistent enforcement of criminal laws in the community that affect teens.

Table 5-3. Committee Tasks

Tasks assigned for each committee
1. Identify needs specific to adolescents within committee area.
2. Identify barriers within committee areas that hinder providing information to teens and delivering needed services to teens.
3. Identify tasks which may be accomplished within committee area to assist teens and to prevent pregnancy.
4. Increase awareness of the need for teen pregnancy prevention and incorporate leaders in the committee area in developing intervention strategies.

Meeting Activity: Identifying Strengths In Jacksonville

During the first round of committee meetings, attendees participated in a brainstorming session to identify strengths in their community sector. At each sector committee meeting, the project coordinator facilitated a discussion (and wrote on a poster clipboard) about strengths relating to pregnancy prevention in the committee sector they were representing (e.g., religious, health/medical). For example, during the initial meeting of the Social Services committee, members identified on the poster clipboard the following strengths in Jacksonville's social services sector in addressing adolescent pregnancy prevention:

- Neighborhood advisory groups – Plan It! Do It!
- Jacksonville Children's Commission
- Strong collaborative efforts between services providers, funders, and government
- Many services are available
- Climate of awareness of growing and changing in services and needs
- Funding criteria – increasing demands
- Jacksonville Alliance

Participants in the Media sector committee identified the following strengths within Jacksonville's media community in addressing adolescent pregnancy prevention:

- Community commitment
- Networks well represented
- Variety of radio stations represented

- Jacksonville University, Jones College, University of North Florida's stations and newspapers
- Many local publications: Folio, Jacksonville Business Journal, Jacksonville Family Magazine
- Minority publications: Advocate, Florida Star
- Naval presence in community
- Special events like Expos and the Jacksonville Jazz Festival
- Internet access (creation of a web site/home page
- Donated billboard space
- Bus signs

Health and Medical committee members identified the following strengths within the health and medical sector community in addressing adolescent pregnancy during their initial meeting:

- High number of community health providers
- Supportive school board chairperson
- Jacksonville Community Council Inc (JCCI) study
- United Way – corporate volunteers, funding source
- Junior League
- Media support
- Comprehensive sexuality education
- Strong multi-cultural organizations
- Duval County Public Health Unit field services
- Religious community
- Support for services from corporate sponsors, managed care providers (potential project and/or barrier)
- Training programs for medical providers (UF, UNF, JU, etc.)

- Indigent care
- Healthy Start/Healthy Families
- Navy

The project coordinator indicated that each committee could use the list of strengths that was compiled to build upon and use in designing new intervention projects. The expectation prevailed that by using resources that existed in the community, the Jacksonville Alliance's efforts could be more effective and productive.

The project coordinator also explicitly recommended that during Phase I, it might be beneficial for some committees' efforts to have joint committee meetings and to work closely with one another. Nevertheless, the sector committees continued to meet independently during the first year of life of the coalition. No one, except for the Religious Community committee chair, took the initiative to collaborate across committee boundaries. Despite the fact that she attended other committee meetings (e.g., Media), it was not possible for this field worker to detect a substantive happening that might have occurred.

During round one, before each committee meeting was adjourned, the project coordinator announced the committee chair, date, time, and location of the next committee meeting. Except for the Religious Community committee and the Parents and Community committee, all of the committee chairs had already been pre-selected by the project coordinator. For future meetings, committee members collectively decided the date, time and location of sector committee meetings. This brings to a close round one of the sector committee meetings.

The Second General Coalition Meeting of the Jacksonville Alliance

On March 21, 1996, the second general meeting of the Jacksonville Alliance was held at 5:30 p.m. at the FCCJ Urban Resource Center. Sixty-one individuals including staff attended. Attendees received an information packet that had the following items: an agenda, project staff names/titles, Jacksonville Alliance vision statements, examples of mission statements, objectives worksheet, proposed vision and mission statements of the Jacksonville Alliance, committee meeting schedule, committee goals, biography of Dr. X, and adolescent pregnancy literature.

Jacksonville Alliance Update and Committee Accomplishments

The project coordinator announced that an evaluator had been hired by the DCHD to join the project staff in March. She gave an update on the nine committees of the Jacksonville Alliance, stating that all committees identified strengths in their community sectors during the initial meetings. The project coordinator further stated that the future tasks of each sector committee included identifying needs and barriers related to adolescent pregnancy prevention in the Jacksonville community. She reiterated that committees were to design and implement three projects. Work completed by the committees would be used to develop a comprehensive community action plan that would be presented to the CDC in 1997. At this time, attendees were informed that an Executive committee of the Jacksonville Alliance had been formed.

Formation of the Jacksonville Alliance Vision Statement

During this second general meeting of the Jacksonville Alliance, the project coordinator facilitated a discussion about possible vision statements. Since the first general meeting, staff had taken suggested elements and language that members wanted included in a finalized vision statement and had mailed three possible vision statements

to members. Attendees reviewed the following vision statements that had already been ranked by members through a mail-in ballot.

1. To create and maintain a community-wide effort that opens doors for adolescents by providing them with the incentives and skills necessary to delay pregnancy, establish viable personal goals and achieve success.

2. To incorporate all sectors of the community in a unified effort to give adolescents the support and care they need to avoid unintended pregnancy and to live healthy, rewarding lives.

3. To prevent adolescent pregnancy by providing teens with hope and opportunities for healthy futures, including gainful employment and quality education and increase community involvement in the lives of teens.

A participant as an alternative to the above vision statements offered the following overall vision statement:

> Suggested Alternative: The Jacksonville Alliance for the Prevention of Adolescent Pregnancy will be a force that provides the youth of our community with hope and opportunities for a healthy future. We will incorporate all sectors of the community towards this common goal. We will provide youth a quality education, skills necessary to delay pregnancy, and viable personal goals to achieve success.

The project coordinator facilitated further discussion about the vision statement.

Participants continued to offer more suggestions:

- The vision statement needs to be reflective of successful adulthood (also, fulfilling, responsible, productive adulthood).

- The Jacksonville Alliance will not actually provide the goals for teens, but to encourage teens to draw out the goals from themselves (facilitation and empowerment).

- The Jacksonville Alliance must always try to see things from a youthful perspective and also to not to lose focus of the goal of reducing adolescent pregnancy.

The project coordinator conducted a vote to determine which vision statement would become the Jacksonville Alliance's official vision statement. The alternative vision statement (see above) received the most votes, and the vision #1 (see previous page) was the runner-up. The coordinator stated that both statements would be modified

to become one vision statement and one mission statement. These statements were then mailed and sent to all members for another vote. The project coordinator indicated that the vision and mission statement would be finalized at the next general meeting.

Guest Speaker Dr. X: Communities Working for Prevention

The guest speaker for the second general meeting of the Jacksonville Alliance, Dr. X, a nationally recognized speaker on adolescent pregnancy prevention programs, gave a historical overview of adolescent pregnancy. Dr. X raised the following issues to be considered seriously when the coalition addressed the problem of strategic interventions to abate adolescent pregnancy:

- Many adolescent girls are having babies that are fathered by older men. Younger girls (i.e., 14 or 15 years of age) are more likely to have babies fathered by men who are over 24 years of age than boys of their own age.
- The role of the male in this issue is very important. Child support enforcement through the criminal justice system should be addressed.
- The fact that many adolescent mothers are unwed is an issue that is coming to the forefront in national discussion of adolescent pregnancy.
- The top risk factors in predicting adolescent pregnancy have been found to be 1) single-parent households, and 2) having a pregnant or parenting teenage sibling. Adolescent girls who live in fatherless households begin puberty five months earlier than girls in two parent homes.
- Adolescent pregnancy prevention should be an interdisciplinary effort. New anthropological studies and research from many other disciplines provide important information that can help in the Jacksonville Alliance's efforts.

Subsequent to this presentation of established research findings, Dr. X gave a brief overview of prevention programs and strategies that have worked or do not work. She told the community coalition:

> You don't have to focus on the white teenage girl. You don't have to worry about her. Her white middle-class mother will make sure that she doesn't get pregnant or have a baby. Who you have to focus on is the teen girl who lives in the housing

projects. That's where you need to focus your attention. The most successful child/parent programs work best in the projects.

To the participant observer and listener, Dr. X seemed to provide this advice as if it were part of a casual conversation between two girlfriends who had just run into each other on the street, and were sharing the most recent gossip. The tone of here voice was relaxed, and she had one hand on her hip. Dr. X proceeded with her lecture covering the following information on transparencies. To begin with, she covered

Programs that work:

- One-on-one support from a responsible adult
- Continued engagement in school and educational achievement
- Attention to learning about the world of work and job skills
- Development of specific skills to avoid pregnancy
- Involvement of parents and ALL sectors of the community
- Attention to peer influence and support
- Male mentor programs (e.g., national African male fraternities mentoring programs work well)

Programs that have not worked:

- Information and education alone
- Single intervention programs targeting all teens as a whole
- Contraceptive availability alone
- Abstinence only interventions

This brought the entire meeting to a close. The project coordinator thanked Dr. X for speaking. Next, she asked members to sign-up for a sector committee if they had not already done so, and to give names of people who should be contacted to join the Jacksonville Alliance.

Chronology of the CDC Site Visit and Subsequent Events

On March 25-27, 1996 the CDC staff conducted its first site visit in order to observe and discuss the progress of DCHD and the Jacksonville Alliance as participants in the "Community Coalition Partnership Programs for the Prevention of Teen Pregnancy." The CDC program consultant for Jacksonville and the CDC program evaluator met with the Teen Pregnancy DCHD staff and the director of DCHD. Also, CDC staff met with community representatives and members of the Executive committee that is to say all committee chairs of the nine sector committees of the coalition partnership.

At the end of the site visit, CDC staff gave oral and written feedback to the project staff. They suggested that the staff go through a team building process. There was internal conflict within DCHD Teen Pregnancy staff. The initial grant manager had officially resigned on January 17, 1996 and was now serving as a volunteer.[2] A new grant manager was hired. Soon after the new grant manager was hired, a three-way conflict arose between the new grant manager, the principal investigator, and the project coordinator. The grant manager complained to the CDC that she was not getting administrative support from the DCHD director, and she was eventually forced to resign several weeks after the CDC site visit. The principal investigator also resigned in April. The DCHD director then assumed both the roles of principal investigator and of acting grant manager until a third grant manager was hired in June 1996. However, the DCHD director remained principal investigator throughout the duration of the coalition project.

[2] See chapter 3 for details.

During the CDC site visit, CDC staff reminded the hub organization (i.e., DCHD) and informed the Executive committee that a needs assessment had to be conducted in the zip code areas that were identified in the grant application. Using the medical model of viewing teen pregnancy as a disease, CDC staff was concerned about eradicating teen pregnancy in the geographic areas where it was identified as a problem. It was reemphasized that the coalition's interventions projects had to be structurally connected to a needs assessment.

In response to this CDC request, members of the Executive committee stated that a needs assessment had already been done the previous year in Jacksonville and another assessment was not necessary. Members referred to studies that were conducted in 1995 by several organizations. The First Coast Adolescent Health Consortium (FCAHC – the initial designated coalition in DCHD's grant application to the CDC) administered a Teen Sex Survey in spring, 1995. Moreover, the Jacksonville Community Council Inc. (JCCI) had prepared a report entitled "Teenage Single Parents and Their Families Study" in the spring of 1995. Results from a zip code based survey administered by DCHD were distributed in September 1995 in a report entitled "Plan It! Do It!"

Unswayed by these arguments, CDC staff insisted that a special project-focused needs assessment still had to be conducted for the targeted community. CDC staff recommended developing focus groups and surveys in doing a community needs assessment. They suggested that the project share the findings with adult and teen residents in the targeted neighborhoods so that residents could interact and react personally to the findings. In particular, CDC noted that this process would sensitize the

project staff as well as encourage people to get involved and defend the teen pregnancy prevention program efforts.

In terms of coalition development, CDC staff recommended that a Policy Advisory Group be established. In their opinion, such an organizational entity would help to enrich the vision as well as solidify long-term program investment commitments, that is, resources that are needed to implement interventions. CDC staff also recommended that the coalition partnership assume a public relations-type positive focus of the program. They gave this statement as an example, "the development of youth – the key to the economic development of Jacksonville." CDC staff explained that it was easier to mobilize resources for teen pregnancy prevention when prevention efforts focused on the positive aspects of the community. CDC staff also stated that another CDC funded teen pregnancy prevention program in Yakima, Washington was taking a "positive approach" rather than a "negative approach." This directed attention to, for example, parents who have little parenting skills and are known to have high-risk teens who get pregnant.

The CDC staff, furthermore, admonished the project staff and Executive committee members to actively involve youth to identify other youth to serve as standing members on at least some of the coalition's sector committees, and to try to involve youth to assist in the project mission on a task specific basis. Likewise, CDC counseled the project staff that ground rules between members of the Jacksonville Alliance needed to be established. CDC argued that this would help "stepping away from the table on some issues, and coming back to the table on other issues. To illustrate their point, CDC opined that some sector committee "members may withdraw their participation on a coalition project because they do not agree with a position of the coalition such as condom distribution."

The CDC site visit group was quite copious in giving suggestions for intervention program development. Some of the major suggestions were:

- Leverage Neighborhood Advisory Groups (e.g., use their networks within the targeted community), and other strategies to mobilize community participation during the planning, field testing, and implementation. Early "at the table" involvement as true partners is the best investment for long-term involvement.
- Seek participation of authentic opinion leaders and newly energized residents in each coalition committee.
- Bring youth that are experienced, and represent organized groups of youth in project zip code areas in each of the Alliance committees, as standing members of these committees.
- Begin developing a model for a comprehensive, community-wide (going to scale from the targeted community to overall Jacksonville community) intervention program that will be effective and sustainable now.
- Use needs assessment information as it becomes available to continuously shape and change the program model. Develop a model that can (1) provide a framework for the work of the committees, and (2) help ensure that intervention program components are reinforced and linked.

Round Two of Sector Committee Meetings

The second round of sector committee meetings for the Jacksonville Alliance took place April 9-18, 1996. The meeting of the Parents and Community committee was rescheduled due to low attendance. Committees met for approximately one hour and followed the same format as before. Members received information packets that included the following: an agenda, a committee roster, a committee packet overview handout, literature on adolescent prevention strategies, prevention programs summary and assessments, and adolescent sexuality research.

Sector Committee Tasks for Round Two of Committee Meetings

Each committee reviewed and approved the meeting minutes from their initial meetings. After reviewing the strengths in the community for carrying out prevention

efforts, the project coordinator informed members that they were to identify barriers in the community that limit prevention efforts.

Primary Meeting Activity: Identifying Barriers in Jacksonville

The Alliance project coordinator facilitated each committee through a brainstorming activity of identifying barriers in their sector of the Jacksonville community. In order to exemplify this process, several illustrations from the total corpus of meeting data are provided now. The three-sector committee meetings selected for the purpose of illustration are essentially similar to the other six-sector committee meetings during this round. The Religious Community committee, for example, engaged in a discussion of perceived barriers related to teenage pregnancy prevention in the Jacksonville religious community. The following barriers were listed:

- Diversity (also a strength) in race, geographic location, economics in congregations
- "Inner reach" versus "Outer reach" (e.g., congregations that focus only on church members and not the community in which they are located)
- Lack of youth issues/youth focus (e.g., congregations without youth ministries)
- Lack of cooperation among churches

The Business/Civic committee provides another good example of the variety of identified barriers that relate to teen pregnancy prevention in Jacksonville.

- The "good 'ol boy" network (i.e., socio-economic clique of white men in power)
- Separation of minority business leaders from white business leaders
- Complexity of issue: teen sexuality, pregnancy, children raised by teens, abortion, birth control, race
- Distribution of resources where they are needed without laying blame
- Religion as a cultural factor and differences between congregations

- Parents not taking responsibility for their children and lack of basic parenting skills (i.e., what is normal adolescent behavior)
- Lack of law enforcement relating to adult fathers and child support
- Powerful messages in the media about sexuality, relationships, gender roles
- Different attitudes and expectations for each gender
- Poverty generates teen pregnancy problems: lack of future, opportunities, education, lack of expectations
- Bright and talented youth move away and Jacksonville businesses lose talented employees
- Attitudes about pregnant teens, status in community/peer group
- Cultural norms and multi-generational teen pregnancy behavior

The Government/Law committee produced the following list of barriers:

- Parents, agencies, and educators all need a better understanding of laws relating to sex crimes
- Reporting issues which relate to balancing trust of client with desire to report sex crime to the authorities (e.g., social service provider told by teen that the father is an adult male)
- Having to report to the Sheriff's office because Human Rehabilitative Services (HRS) will not accept calls at the "800" number
- Interviewing by Sheriff's office may interfere with giving history/information
- Problems with older males impregnating younger females
- Lack of truancy enforcement and lack of curfews laws (e.g., teens not in school are more likely to engage in sex)
- Cultural norms give mixed messages about what is acceptable behavior

Before the end of the April 9-18, 1996 sector meetings during round two, the project coordinator told committees that the CDC site visit was successful. Each committee agreed to meet within four to eight weeks at DCHD or at a convenient place of choice of a committee member's organization. The project coordinator informed all

committees of the upcoming general meeting of the Jacksonville Alliance. She told them that Dr. Y, an anthropologist, was scheduled to be the guest speaker.

Third General Coalition Meeting of the Jacksonville Alliance

On May 1, 1996, the third overall meeting of the Jacksonville Alliance took place at the FCCJ Urban Resource Center at 5:45 p.m. Fifty-nine individuals including staff attended this meeting. Members received an information packet that included: an agenda, project staff names and titles, Alliance packet overview, mission and vision statements, biography of Dr. Y, nine tables of Duval County Teen Data 1991-1995, scientific adolescent pregnancy literature, May/June 1996 committee meeting schedule, committee descriptions, committee rosters, committee tasks, and committee goals timeline. The agenda, Alliance packet overview, and committee-meeting schedule are provided in Appendix D as a sample of materials that members received.

Jacksonville Alliance Committee Update

At the third general meeting, the project coordinator reviewed the sector committee work: (1) the committees had completed identifying areas of need in the Jacksonville community, (2) within each committee area, strengths and barriers in teen pregnancy prevention in Jacksonville were identified, (3) the strengths and barriers were to be incorporated into intervention goals for Jacksonville. She provided a summary list on transparencies the following common strengths and barriers identified by many committees:

Common strengths

- Comprehensive community involvement
- Strong youth service agencies and programs

- Duval County School Board's recent implementation of health and sexuality curriculum
- Strong collaborative efforts of youth and family service providers (including health Families Jacksonville, Family Transition Program)
- Strong youth funding (Jacksonville Children's Commission, United Way, Jaguars Foundation)
- Movement to community-based service provision (Full Service Schools, Duval County Public Health Department Field Service Delivery System)
- Increased awareness to issues related to teen sexuality and prevention (Jacksonville Community Council Inc., health and sexuality curriculum)
- Strong religious community and presence in Jacksonville
- Many large corporations and civic groups in Jacksonville interested in community involvement
- Commitment of media leaders to the issue

Common barriers

- General conservative nature of the community
- Lack of funding for prevention efforts
- Access to students in Duval County Public Schools with information and services
- Client confidentiality issues create difficulties with information sharing between programs/agencies
- Differing opinions of pregnancy prevention
- Peer pressure
- Media influences
- Lack of access to services and information
- Lack of parental involvement
- Issues of poverty, unemployment, and abuse within families
- Difficulty in prosecuting minor/adult relationships due to non-cooperation and lack of information

- Lack of expectations for youth
- Different attitudes and expectations for each gender (male responsibility)
- Bright and talented youth move away from Jacksonville

As a follow-up to these lists, the project coordinator announced that the next step in the sector committee planning process would be to set primary goals for prevention within each of the committee areas.

Jacksonville Alliance Vision and Mission Statements

During the same meeting, the project coordinator also unveiled the vision and mission statements of the Jacksonville Alliance. She read the final vision and mission statements before the assembled members:

Our vision

> We envision a community where teens have hope, skills and opportunities for a healthy and successful future.

Our mission

> The Jacksonville Alliance for the Prevention of Adolescent Pregnancy will unify the community to create opportunities for adolescents and their futures. The Alliance is committed to the success of Jacksonville's youth by ensuring community support and services that emphasize educational achievement, promote the skills necessary to delay pregnancy, and focus on attaining viable personal goals.

The members approved the statements without amendments.

Guest Speaker Dr Y: Adolescent Pregnancy Issues and Our Community: Learning to Listen to Teens

The next item on the May meeting agenda was a presentation by the guest speaker. Dr Y, a medical anthropologist and advocate for maternal, child, and adolescent health, began her presentation by discussing the definition of the problem of adolescent pregnancy prevention for the Jacksonville community. She stated that whether or not

adolescent pregnancy is considered a problem varies across many different groups. Depending on the perspective of the community, teen birth rates can be considered high or low. Hence, a local understanding of this issue must be the basis of all efforts to address the problem.

In order to provide a quantitative analysis of the teen pregnancy problem in Jacksonville, Dr. Y presented data collected in Jacksonville from birth certificates of babies born to teen mothers. She recommended that the Jacksonville Alliance take time to decide where to focus its efforts. She illustrated her remarks with "do we want to prevent all teen births or just births to girls under age 18?" She made a special point of clarifying which group of teens (e.g., younger, older, females, males) should be targeted. She was quite emphatic that this issue should be addressed before the Jacksonville Alliance proceeded further.

Dr. Y also stressed the importance of talking to Jacksonville youth in order to gain a full understanding not only of the adolescent pregnancy issue but also of other current issues facing youth. She recommended the following strategies when developing new adolescent pregnancy prevention programs:

- Talk to teens all over town; listen to them, especially in their peer groups in schools and outside of schools.
- Talk to boys and girls separately as well as together.
- Visit individual schools and learn about them. Each one is different from the others.
- Target sixth through ninth grades that seem to be the hardest years for teens in Jacksonville.
- Let teens come up with workable strategies.

The project coordinator thanked Dr. Y for speaking to the Jacksonville Alliance. She announced that Dr. Z from the ABC Organization for Girls for the State of Florida was the scheduled guest speaker for the next general meeting of the Jacksonville Alliance.

Round Three of Sector Committee Meetings

The third round of committee meetings for the Jacksonville Alliance occurred between May 15, 1996 and June 7, 1996. The following materials were disseminated at the committee meetings: an agenda, committee packet overview, excerpts from "Getting Results and Knowing It" prepared for the United Way of Northeast Florida and the Jacksonville Community Council Inc., objectives worksheet, mission and vision statements, Duval County School Board Comprehensive Health Education Program Parent Handbook, and adolescent pregnancy prevention life options "Reasons to Wait: Enhancing Life Options," an article in Family Life Educator, Fall 1990.

Committee Tasks for Round Three of Sector Committee Meetings

All round three committee meetings followed the same format and process. After reviewing identified strengths and weaknesses from the previous committee meetings, the project coordinator indicated that each sector committee would begin the process of developing goals and objectives for the community sector that their committee was representing. She also suggested that each committee develop objectives at their next meeting.

Meeting Activity: Identifying Sector Committee Goals

To begin with, committee members reviewed the previously formulated mission and vision statements of the Jacksonville Alliance. The Alliance project coordinator referred members to excerpts from "Getting Results and Knowing It." She read from this

handout on the criteria for developing goals and objectives. Members discussed possible goals for their committee. Members categorized major themes, and each committee formulated goals. The following sector committees illustrate the process that all sector committees completed during round three. The activity of the Education, Parent and Community, Business/Civic committees are presented now. The Education committee enumerated the following issues of concern:

- Increasing parental involvement in the implementation of the new health and sexuality curriculum (collaborate with the Parents committee)
- Monitoring the training and on-going in-service of educators teaching the new curriculum
- Setting up career days and/or internships with the business/civic community (collaborate with the Business/Civic committee)
- Working with parents through preschools and daycare centers
- Educating the religious community by involving the clergy
- Developing a network of resources for tutoring and referral to tutorial services
- Considering cultural differences and gender issues
- Reaching kids who are not in school

After discussing these issues, members of the Education committee decided upon the following goals:

- To support the Duval County School Board's implementation of the Health and Sexuality Education Curriculum
- To develop a network of current services available in Duval County for tutoring and mentoring
- To provide sexuality education and training to daycare and preschool providers and educators
- To increase community awareness about high truancy rates and to develop resources for adolescents not in school

During their third scheduled meeting, the Parents and Community committee engaged in a discussion to determine the goals of the committee. This committee as a whole explored the following issues:

- Evaluating the needs of parents
- Identifying natural leaders in neighborhoods
- Assisting parents to develop effective relationships with their teens, including appropriate discipline techniques
- Finding places to reach parents, PTAs, Family Transition Program
- Conducting "brown bag" sessions to disseminate information to parents
- Soliciting support from businesses and churches
- Collaborating with other committees
- Recruiting peer mentors for parents who need help (parents helping parents)
- Increasing parent participation on this committee
- Increasing male involvement in this issue
- Determining the scope of the problem and which segment to address

After brainstorming potential goals, members of the Parents and Community committee discussed these goals in detail:

- To encourage more parental involvement in their children's lives
- To provide parents with skills and knowledge to be more effective parents
- To increase parents' awareness of teens' behavior, activities, and needs
- To establish relationships with various organizations to disseminate information to parents
- To recruit peer parent teachers to assist those in need to develop parenting skills
- To increase membership in this committee by recruiting of parents of teens in the community

The Business/Civic committee members began the process of identifying goals at their third meeting. Members focused on the following issues that would be used in developing the goals and objectives of their sector:

- Increasing awareness and involvement among the business community to issues of teen pregnancy and prevention
- Recognizing the initiatives of local business efforts in addressing teen pregnancy (recognition, awards)
- Continuing efforts to involve small businesses
- Encouraging businesses to "Adopt A Kid" – a teen for each business organization
- After further consideration, the Business/Civic committee chair presented the following overall goal for the committee members: "To mobilize the business community through education and awareness; affirmation of initiatives; and involvement in the Alliance and development of new ideas." The chair then asked members to consider this goal, and to suggest any comments or changes at the next committee meeting.

Toward the end of this particular meeting, one project staff person asked the committee about efforts to involve African-American businesses located in targeted community of zip code areas with high teen birth rates. One member replied, " the committee had decided that we would go ahead and plan interventions, and we would ask for African-American businesses for their input after the interventions had been planned." No one else offered a further comment to this statement. Apparently, this committee seemed satisfied to gloss over the particular needs and involvement of salient local cultures in the work of the committee. In a manner of speaking, the Business/Civic committee members seemed to legitimize their behavior by considering themselves experts.

The Fourth General Coalition Meeting of the Jacksonville Alliance

On June 27, 1996, the fourth general meeting of the Jacksonville Alliance was held at the FCCJ Urban Resource Center at 5:40 p.m. Fifty-two members including staff attended this meeting. Members received the following items: an agenda, a Jacksonville Alliance packet overview, project staff titles and names, sector committee goals (i.e., a draft summary), a June/July committee meetings schedule, a membership feedback form, Jacksonville Community Council's Teenage Single Parent and Their Families Memo to the Alliance Membership, The guest speaker's Dr. Z's Biography, a press release from the Robin Hood Foundation, The National Campaign to Prevent Teen Pregnancy Project Summary, adolescent pregnancy prevention research: "Community, Youth Development: Three Goals In Search of Connection" by Karen J. Pittman in New Designs for Youth Development, Winter 1996.

Jacksonville Alliance Committee Update

The project coordinator began the meeting with a review of the progress of the Jacksonville Alliance. She pointed out that, first, the committees identified strengths in their sector areas that were relevant to adolescent pregnancy prevention. Second, she reported that committees identified barriers in adolescent pregnancy prevention in Jacksonville. At this moment, according to her, the committees were in the process of developing goals and objectives to guide their activities in adolescent pregnancy prevention. The coordinator restated that committee goals and objectives related to the overall vision and mission of the Jacksonville Alliance. She anticipated that future committee meetings would involve clarifying, prioritizing, and developing action plans for each committee goal.

The coordinator carefully read through the draft of sector committee goals for each committee, and encouraged members to give feedback. Members had a general discussion of the Jacksonville Alliance committees' activities, and the following issues were focused on:

- Job skills training and utilization of existing resources are ways to maximize the efforts of the Jacksonville Alliance to provide the greatest good for teens and to eliminate duplication of efforts.
- Transportation is an issue that must be considered when designing any intervention. (It continues to be a great need in our community.)
- Lack of motivation and depression are barriers to teens utilizing services. These issues should be considered when designing interventions.
- The Jacksonville Children's Commission is currently developing a resource directory for teens. This could be useful for the work of committees.

The project coordinator announced that all sector committees would present their finalized goals to the entire Jacksonville Alliance membership for prioritizing and approval at the next general coalition meeting to be held in September.

Jacksonville Community Council Inc.'s Presentation

Next on the June 27, 1996 agenda of the fourth general coalition meeting was a presentation by the Jacksonville Community Council Inc. (JCCI). A member of the JCCI Teenage Single Parents and the Families Implementation Team made a brief presentation. She explained that in July 1995, JCCI released a study on teen parenting. A result of this study led to the formation of an implementation team to follow up and advocate recommendations that were made in the study. One of the special recommendations was that a group be formed to address the needs of teenage parenting.

She requested that the Jacksonville Alliance add a committee to its current structure to address teenage parenting, "the Pregnant and Parenting Teens committee." She

encouraged coalition members to fill out and return the ballot on the reverse side of the JCCI's memo to the Jacksonville Alliance that was included in the handouts and were distributed at the beginning of the coalition meeting. It was suggested that the ballots would be used to determine if coalition members wanted to add a committee to address the needs of pregnant and parenting teens.

Guest Speaker Dr. Z: Adolescent Pregnancy: A New Perspective

Next, as part of an on-going effort to stimulate coalition members' ability to act in reducing teen pregnancy, the project coordinator had invited a state expert to share information about why some teens are getting pregnant, and to give advice to the entire coalition membership about special funding opportunities to support their intervention programs. The title of Dr. Z address to the group was: "Adolescent Pregnancy: A New Perspective." Dr. Z, State of Florida Director of the ABC Organization For Girls, spoke especially about gender issues related to adolescent pregnancy prevention. She reported results of her own extensive research work.

She interviewed 400 parenting and pregnant teens that were homeless in five major cities across the United States. Most respondents (53.8%) said they were looking for love and attention when asked why they became pregnant. Dr. Z stated that it appears that society was not providing enough support for young girls if they were looking for love and attention through a sexual relationship.

She also spoke on research from the Robin Hood Foundation, entitled "Kids Having Kids." She stated that thirty million dollars were allocated for the 1997 federal budget to address the problem of adolescent pregnancy, and President Clinton made teenage pregnancy prevention a top national priority. Dr. Z further stated that monies

would be distributed to communities and programs that incorporated the following key principles:

- Parental and adult involvement
- Instruction on abstinence and personal responsibility
- Clear strategies for the future of teens
- Community involvement with public and private partnerships
- Sustained and long-term community involvement

Dr. Z concluded her talk by encouraging the coalition to seek these funds by contacting the National Organization for Adolescent Pregnancy, Parenting, and Prevention (NOAPPP). The project coordinator thanked Dr. Z for her presentation and she urged everyone who had not as yet joined a sector committee to sign-up for a committee of their choice.

Round Four of Sector Committee Meetings

The fourth round of committee meetings took place from June 26, 1996 to July 16, 1996. The Religious Community committee sector meeting had to be rescheduled due to low attendance. Also, the Business/Civic meeting was cancelled and was rescheduled during this round.

Committee Tasks for Round Four of Committee Meetings

For starters, every sector committee received a handout on tasks to be covered during this round of meetings. All committees received an agenda and an objectives worksheet. The project coordinator stated that each committee was to list objectives for each committee's goal. She asked committee members to think about what they were trying to accomplish. She told members that objectives were to be specific, measurable, attainable, relevant, and time bound.

Meeting Activity: Identifying Sector Committee Objectives

This chronological narrative commences with the activity of objective identification. Each committee having reviewed its goals, began the process of listing objectives that would be completed to achieve the agreed upon goal. Committee goals and objectives were to guide members in their selection of interventions for the coalition as a whole.

The work of four sector committees is illustrative: the Social Services committee, Health & Medical committee, Parent and Community committee, and Teens committee. The following example of activity occurred during the Social Services committee meeting. The committee reviewed the goals discussed at the previous meeting.

Goal 1: To define adolescent pregnancy prevention programming for agencies.

Goal 2: To increase access to the public school system for all social service providers.

Members decided that social service agencies in Jacksonville might not readily accept or need a definition of teenage pregnancy prevention programming. The committee engaged in a discussion that led to the formulation of a new goal. Goal 1 (revised): "To facilitate networking between social service agencies including initiating collaboration and encouraging information sharing."

The committee identified the following preliminary objectives for this revised Goal 1:

- Using a common definition of teenage pregnancy prevention programming to link agencies in the network
- Providing resources and education on teenage pregnancy prevention in the social services community
- Increasing access to a client database tracking system
- Developing a resource directory for service providers

- Creating a newsletter of current information for social services providers that will provide an overview of happenings in agencies within the social services community, including training, reviews of curricula and materials
- Involving funding agencies in the development of the provider network and the definition of teenage pregnancy prevention programming
- Involving teens in the Social Service committee's activities

Members decided that the objective for Goal 2 was to use the Jacksonville Community in Schools programs (formerly "Cities in Schools") as a resource or an avenue to enter the school system. The Jacksonville Community in Schools Program offers social services such as counseling, to high-risk teens in many Duval County Public Schools.

The following example of meeting activity occurred during round four of the Health & Medical sector committee meeting. Members of this committee reviewed two goals that were identified in the previous committee meeting.

- Increase skills and knowledge of medical professionals and others in the areas of teen sexuality and pregnancy prevention through legislative mandate requiring training to receive licensure
- Create a network of teen health service clinics, incorporating existing and new providers with emphasis on effective marketing, increasing utilization, and proper follow-up and tracking procedures

Committee members discussed the pros and cons in attempting to achieve the first goal. The discussion primarily focused on the time constraint of implementing the legislative mandate requiring training to receive licensure. The committee then decided to eliminate the legislative mandate clause from the first goal.

Given the work required developing a teen clinic network, members decided next to have only one sector committee goal. They chose to focus on the overall goal of "creating a network of teen health service clinics that would incorporate existing and new

providers." The former goal "to increase skills and knowledge of medical professionals in the areas of teen sexuality and pregnancy prevention," was changed into an objective of the overall committee goal. The committee then proceeded to identify additional objectives to achieve this goal.

- Increase awareness with health and medical professionals through training programs
- Encourage health professionals to increase awareness of parents for the need to discuss sexuality issues at younger ages
- Create a speakers bureau of health professionals to reach out to civic and community groups
- Identify collaborating partners
- Identify funding sources
- Develop a marketing strategy and campaign
- Determine clinic locations
- Develop the coordination structure
- Develop the peer educator program
- Determine logistics of clinics (hours, appointments)
- Handle computer tracking and client information and confidentiality issues
- Determine fees for services

Another example of meeting activity occurred during the Parents and Community committee meeting. Members reviewed the six goals that were discussed in the previous meeting. One member requested that committee members collectively prioritize and consolidate their sector committee goals, while remaining focused on what is realistically attainable. After much discussion, the revised goals and objectives of the Parents and Community committee were promulgated as follows:

Goal 1: To increase parental involvement in the lives of their youth

Objective 1: To provide parents with skills and knowledge to be more effective parents

Objective 2: To increase parents' awareness of teens' behavior, activities, and needs

Objective 3: To recruit peer parent teachers to assist those in need to develop parenting skills

Goal 2: To assist parents in accessing services that will help them provide their youth with more opportunities for success

Objective 1: To establish links between agencies

Goal 3: To increase parents' involvement in community organizations and issues that affects the lives of youth

Objective 1: To increase membership in the committee through recruitment of parents of teens in the community

Members of the Parents and Community committee decided to finalize the goals and objectives at the next meeting. The committee agreed to develop timelines for accomplishing the goals and objectives at that time.

Another example of typical meeting interaction took place during the Teens committee meetings. Members reviewed goals that were discussed at the previous meeting, and discussed the Teen Orientation initiative that was to be planned for July 1996. The committee as a whole was comprised solely of adults. They planned to recruit teens to participate in the Teens committee and all other committees of the Jacksonville Alliance at a future date. They discussed that teen input at the committee level was eventually necessary when planning successful teen pregnancy prevention programs. The committee agreed on the following goals:

- Goal 1: To ensure the inclusion of teens in the Jacksonville Alliance for the Prevention of Adolescent Pregnancy

- Goal 2: To increase awareness of issues concerning male involvement in pregnancy prevention in the Alliance and in the community
- Goal 3: To strengthen existing peer monitoring and peer counseling efforts and enrich programs in this regard

The committee then went on to identify these objectives:

- Teens will be represented on each of the Alliance's committees.
- The Teens committee will identify strategies to integrate teens who are not involved into organized programs.
- The committee will develop criteria for selecting of teens.
- The committee will train and support ongoing education and motivational needs of teens involved in the Alliance.
- The committee will develop a feedback mechanism for teens to evaluate the respective committees and the Alliance.

The Teens committee members further decided to suspend any future planning of intervention programs for their sector committee until teenagers became involved in the process. Hence, members decided that their next meeting would include teenagers from the various agencies of committee members. Committee members agreed to bring at least two teenagers each from their program or agency. Members did not differentiate whether teens were to be selected from a targeted or geographic area, or whether they included persons from early or late teen years.

At this special meeting with teenagers, committee members decided to open up the meeting with an icebreaker activity, serve refreshments, and to make a presentation to teens about their committee and the other sector committees of the Jacksonville Alliance.

Special Meeting of the Teens Committee

On July 17, 1996 the Teens committee of the Jacksonville Alliance convened a special meeting with teenagers from member service agencies within the Jacksonville

Alliance. There were 14 adults and 14 teenagers. As planned, the project coordinator started the meeting with an icebreaker activity. Both adults and teens participated in the icebreaker activity. Each person introduced the person next to him/her and told the person's "most embarrassing moment." Some participants stated that the person next to him/her never had an embarrassing moment.

Next, the project coordinator presented an overview of the Jacksonville Alliance. She read the mission and vision statements of the Jacksonville Alliance, and she discussed the structure of the community coalition. She emphasized that teen input was needed, and that this was the first meeting to ensure that teens were involved in the decision-making process and activities of the Jacksonville Alliance.

Teens were asked to break up into groups, and to brainstorm as a group. They were charged to answer the following questions: 1) "Who should be recruited?" 2) "How should we recruit them?" 3) "What do you think about teens getting pregnant?" 4) "Why do teens have sex?" and 5) "What do you think can be done to prevent teenage pregnancy?"

The project coordinator wrote down the responses from the teenagers on a poster clipboard. The responses made are listed here as they were on the poster board, according to topical coverage:

(1) Who should be recruited?

- Teens from diverse backgrounds
- Ages 13-19
- Teens with and without children
- Teens who are interested, motivated, concerned, and dependable
- Teens who are in leadership positions
- Teens with open minds and positive attitudes

(2) How do we recruit them?

- Word of mouth recruitment
- Media, school newspapers
- School-based organizations
- Community groups
- Churches
- Teen volunteer organizations

The following answers were given to the remaining questions:

(3) What do you think about teens getting pregnant?

- It is depressing and painful
- It is an endless cycle with long-term consequences
- Girls get pregnant for the wrong reasons like to keep a boyfriend, to try to be popular, to be an adult, or to receive welfare
- Teens think it will never happen to them

(4) Why do teens have sex?

- Curiosity
- Media/advertising influences
- Irresponsibility
- Lack of education about sex
- No self-respect or self-esteem
- Pleasing boyfriend/girlfriend
- Looking for affection
- Different morals and values
- Lack of role models
- Peer pressure
- Because they can get away with it
- Because they want to
- Feeling like an adult
- Different expectations for boys and girls
- Hormones

(5) What do you think can be done to prevent teenage pregnancy?

- Promote abstinence in peer groups
- Education
- Promote relationships and decision-making skills
- Make it cool to not be sexually active
- Positive role models

- Provide education and services for teens who are having sex
- Link having sex to having babies in teens' minds
- Teach consequences and prevention
- Dispel myths like welfare benefits if pregnant and being an adult
- Increase teens' understanding of the responsibilities of having a child
- Promoting responsibility of males and females
- Addressing the problem of adult males having sex with teenage girls
- Increase parental involvement and trust
- Make sure kids know how it can happen to them
- Let kids know they can be somebody without having sex

At the conclusion of this meeting, the project coordinator told teens that they would receive in the mail a list of all goals of the nine sector committees in the Jacksonville Alliance. She encouraged them to bring their ideas relating to any of the committees' goals and objectives to the next scheduled Teens meeting. She thanked them for their participation.

Round Five of Sector Committee Meetings

The fifth round of committee meetings was held from July 16, 1996 through September 10, 1996. The project coordinator distributed a meeting agenda during this round of sector committee meetings.

Committee Tasks for Round Five of Sector Committee Meetings

The project coordinator used the same format for sector committee meetings as before in the previous round. The project coordinator stated that members were to finalize objectives for the goals that were identified during previous meetings. Likewise, action plans for each committee goal were to be developed.

Meeting Activity: Finalizing Committee Goals, Objectives, and Action Plans

Members in each sector committee began to identify and prioritize committee projects based upon the goals and objectives of the committee. Table 5-4 provides an overview of sector committee projects to be addressed first by each committee. It shows

what sector committees had achieved by Round Five, nine months after the Jacksonville Alliance was formed. The project coordinator reminded committee members that after projects were pilot tested, the committee projects would represent the coalition's interventions to be included in the overall community action plan.

The transactions of the Teens committee, Business/Civic committee, and Religious Community committees are now presented as typical illustration of the workings of all the sector committees during round five. The following example of activity occurred during the Teens committee meeting.

Although teenagers had attended the previous meeting, there were no teens in attendance at this meeting. Committee members reviewed the feedback collected from teenagers at the earlier meeting and discussed several issues regarding teen participation in the Jacksonville Alliance. Members identified and discussed possible solutions:

1. In order to ensure that all teens (e.g., sexually active, abstinent, parenting, pregnant) feel welcome and comfortable to participate, members agreed that ground rules should be established for communication and sharing viewpoints during meetings.

   Solution: Develop a training/orientation for teens new to the Alliance. Do not require them to identify themselves with an organization (e.g., church, school, social service program); this may inhibit teens expressing their true feelings.

2. Teens should be an active part of all existing committees, and contribute to the planning and implementation of committee projects.

   Solution: Teens will be trained through the Teens committee; then they can self-select to participate on any committee. Meeting times may have to be altered to adjust to teen participation. Transportation may have to be provided. Training may need to be provided to committee chairs on how to involve teens effectively in their meetings.

3. Teenage representatives within the Jacksonville Alliance should be diverse in age, ethnicity, and background.

   Solution: Put a cap on teens at 50; hopefully, 15 to 20 teens will participate on a regular basis. Members decided to start working with teens who participated at the earlier meeting.

4. The Teens committee must be creative with ways to keep teens involved.

   Solution: The Teens committee will offer regular "rap sessions" where teens can come together, share information, give feedback to adult committee members, and have fun. Members discussed the need to have a logo and promotional materials for teens (e.g., t-shirts, key chains).

Table 5-4. Primary Goals and Objectives of Sector Committees

Committee And Number 1 Goal	Committee Number 1 Project Objective
Social Services Committee To facilitate networking between social service agencies including initiating collaboration and encouraging information sharing.	Create a resource center/lending library for service providers that would have curricula, videos, brochures, agency newsletters, calendars of events.
Education Committee To support the Duval County School Board's implementation of the Health and Sexuality Education curriculum.	Create a needs assessment survey for educators regarding the Health and Sexuality Education curriculum.
Business/Civic Committee To mobilize the business community in adolescent pregnancy prevention efforts.	Recruit and involve local and regional businesses in the Alliance.
Media Committee To increase awareness through a variety of communications outlets to various target audiences of the consequences of teenage pregnancy and the advantages of delaying parenthood until the adult years.	Create a pregnancy prevention promotion targeting parents.
Government/Law Committee To educate physicians, counselors, HRS personnel and others who work with pregnant teens about reporting requirements for abuse.	Clarify specifics and penalties for former and newly passed laws in Florida as related to adult-minor sexual contact (child abuse statutes, lewd and lascivious statutes).
Health and Medical Committee To create a network of teen health services clinics, incorporating existing and new providers with emphasis on effective marketing, increasing utilization, and proper follow-up and tracking procedures.	Identify collaborating community health partners and identify funding resources.
Parents and Community Committee To increase parental involvement in the lives of their youth.	Provide parents with skills and knowledge to be more effective parents.
Religious Community Committee To utilize the faith community as a valuable resource (space, money, programs, volunteers, outreach) for youth services and pregnancy prevention efforts in Jacksonville.	Develop, promote, and distribute a resource guide on existing religious youth programs and family oriented programs within the faith community.
Teens Committee To ensure the inclusion of teens in the Jacksonville Alliance.	Recruit teens from targeted neighborhoods, service agencies, religious organizations and schools.

Members decided that the first action step was to hold a Teens Orientation session.

The date for the orientation was scheduled for Saturday, September 21st from 10:00 a.m.

to 12:00 p.m. The committee agreed on the following objectives for this Teens Orientation.

- Introduce the history of the Jacksonville Alliance, and clearly explain the process followed by the Teens committee
- Explain why and how teen involvement was so important
- Encourage teen participation at the next general meeting of the Jacksonville Alliance
- Create a unique invitation for teens
- Keep it short
- Offer transportation
- Provide food
- Have fun

Another typical example of activity occurred during the Business/Civic committee meeting. The committee chair led the group in a discussion to review the committee's three goals and to determine how to achieve them. Members agreed to have one central goal, with three objectives (in priority order) rather than several goals as previously determined. Originally, the first and third objectives were identified as goals.

Goal: To mobilize the business community in adolescent pregnancy prevention efforts.

1. Recruit and involve local and regional businesses in the Jacksonville Alliance
2. Implement developed (i.e., pre-existing programs that have worked in other communities) prevention strategies and programs in the business community
3. Recognize individual business efforts in developing youth as productive citizens

Business/Civic committee members expressed concern over the dichotomy of "developing" a program for businesses as opposed to "promoting" those programs

already in existence. Members decided to review local, regional and national programs designed for businesses and youth before deciding on which path to take.

The committee discussed the necessity of a unifying message from the Jacksonville Alliance in approaching the business community. Members expressed concern that the Jacksonville Alliance might appear disjointed at this point to the community, and that "you only get one shot" at engaging their interest. The committee chair suggested that after the September general meeting, the projects should encompass two or three themes under the Jacksonville Alliance's mission which could be highlighted and promoted by the business community.

Committee members compiled a list of action steps that needed to be taken by the business committee, project staff, and entire Jacksonville Alliance membership before attempting to engage business leaders.

1. Compile a cost/benefit analysis of teen pregnancy in our community … what does teen pregnancy cost the community?
2. The Alliance must agree by consensus on a few major thrusts for prevention and intervention programs/projects through which the business community can be involved.
3. The Business/Civic committee needs a good idea of what programs exist both locally and nationally for business and youth.

Another example of activity during round five comes from the Religious Community committee meeting. The committee reviewed and discussed its goals that had been established at prior meetings. Members agreed to a primary goal and to use the other goals that were identified as overall guidelines for the committee's actions.

Goal: To use the faith community as a resource (space, funding, programs, volunteers and outreach) for youth services and pregnancy prevention.

- To raise awareness of each individual's importance as a child of God

- To promote strong abstinence-based programs for youth (abstinence as the expected standard with attention to accurate information)
- To bring faith communities (e.g., denominations) to accountability for their neighborhoods

Members then proceeded to develop objectives and action steps to accomplish the committee's primary goal. The committee discussed the potential wealth of existing programs within the Jacksonville community, and brainstormed on an effective method to share information and encourage cross denomination participation in programs. Members agreed on this general objective: "To develop, promote, and distribute a resource guide on existing religious youth programs and family oriented programs within the family community."

The committee outlined several action steps to accomplish this objective:

1. Identify faith organizations that could participate in this project and help collect and distribute information.
2. Identify churches within faith communities from whom we want to collect program information.
3. Identify specific youth and family program information with the churches and synagogues.
4. Conduct a phone survey and/or follow-up questionnaire to collect information on churches, faith organizations, their programs, and their willingness to participate in the project.
5. Identify target populations to whom the resource guide would be distributed (social workers, juvenile justice, youth leaders, program managers, teens, parents, social service programs, educators).
6. Evaluate services available within our community one year later.

Members continued to brainstorm on what a future Jacksonville Alliance resource directory should include:

- Faith communities should be listed by denomination.

- Programs should be cross-referenced by activity (e.g., mentoring, academics).
- A map should be included, and programs cross referenced by geographic location.
- Addresses with directions, phone, fax, and program contact name and times available should be listed.
- Target audience for each program should be clearly listed and cross-referenced (e.g., parents, older teens).
- Demographics about the population served by the program should be listed (e.g., number served, ages, gender).

This concludes the activities for round five of sector committee meetings. After the fifth round, some committees met additional times in preparation (e.g., to finalize sector committee goals) for the September 25, 1996 general coalition meeting of the Jacksonville Alliance. The Health and Medical committee met on August 28, 1996 and September 18, 1996. The Parents and Community committee met on September 24, 1996. The Religious Community committee met on August 29, 1996 and September 18, 1996. The Teens committee met on September 3, 1996.

The Social Services committee met on September 11, 1996. The Education committee met on August 28, 1996 and September 19, 1996. The Media committee met on September 16, 1996. The Government/Law committee met on August 27, 1996 and September 11, 1996. Due to low attendance, the Business/Civic committee did not meet again after round five of sector committee meetings before the September 25, 1996 general coalition meeting.

Special Teens Orientation Session

During round five of sector committee meetings, the Teens committee sponsored a special Teens Orientation program on September 21, 1996 in the DCHD auditorium. Twenty-five teens and ten adults attended. Some teens from the special meeting of the

Teens committee held on July 17, 1996 returned for the Teens Orientation. The orientation began at 10 a.m. and ended at 12 p.m. Two adult members of the Teens committee facilitated the meeting.

The project coordinator gave a history of the Jacksonville Alliance. She stated that the purpose of the Teens Orientation was to encourage teens to become active in the Teens committee, and also to join other committees of the coalition. The project coordinator encouraged teens to sign-up for other committees at the end of the orientation.

She stated that the Jacksonville Alliance needed teens' ideas and suggestions in addressing teen pregnancy in Jacksonville. The project coordinator explained that some businesses believed that teen pregnancy was not their problem. Members of the Jacksonville Alliance had to remind local businesses, churches, and social services agencies, that teen pregnancy had become everyone's problem. The project coordinator stated that teens had to take responsibility too for the teenage pregnancy problem because they are a significant part of the Jacksonville community as a whole.

After the presentation by the project coordinator, the facilitators of the Teens Orientation asked the teens what came to their minds when they saw the word "sex" taped all around the room. The teens responded that they 1) didn't pay it any mind, 2) had no feeling, and they 3) felt normal. One facilitator asked the teens what is sex? The teens responded that sex is 1) gender, 2) an intimate volunteered act between two people, and 3) something that can be very negative or positive.

A facilitator asked if "you know what sex is, why would you be afraid to say what it is?" A teen responded that "some may feel comfortable about it but don't want to share

their thoughts." The facilitator asked the teens where did they get the majority of their information about sex? The teens responded: 1) television, 2) friends, 3) programs like this, 4) movies, 5) magazines, 6) teachers, 7) music, and 8) parents. The facilitator asked why more teens did not say parents. A teen replied, "They feel awkward about sex too."

A facilitator asked, "How do you determine the facts about sex since you get a variety of opinions through these sources?" No one responded. The facilitator replied that the adults at the Teens Orientation where there to give them the facts. She stated, "that the word 'sex' ultimately refers to you – what you consider yourself. Regardless of what you do, you should come first. You are the most important person in the world. Whenever, you are in a predicament, the first thing you need to think about is how is it going to effect me?"

One of the facilitators asked the teens to break-up into three groups. Pieces of a store bought box puzzle were divided into three sections. The facilitator asked each group to put together their part of the puzzle; then they were to add their part of the puzzle to the other sections to make a complete picture.

The adults did not participate in this activity; they observed the teens. After the teens had completed the puzzle, the facilitator responded that he was surprised to see how diligently everyone worked. He was surprised that no one asked for the picture of the puzzle. The facilitator asked, "Would it have been easier to know what the picture looked like?" Some of the teens replied, "no," while others replied, "yes, because it would have shown us which color was on top or bottom."

The facilitator noted that Group One finished first. He asked, "What did they do?" The teens responded that they "stayed focused, and followed your directions." The

facilitator stated that Group One reminded him of the Jacksonville Alliance because "so many organizations saw the need to address the problem of teen pregnancy but they all worked individually. We realize that if we all worked together, we would have a better chance solving teen pregnancy. In the process of working together, members of the Jacksonville Alliance developed some guidelines. We developed a vision and a mission statement." The project coordinator for the benefit of the teens then read the vision and mission statements:

Our vision

> We envision a community where teens have hope, skills, and opportunity for a healthy and successful future. As an Alliance, this is our desire.

Our mission

> The Jacksonville Alliance for the Prevention of Adolescent Pregnancy will unify a community to create opportunities for adolescents and their future. The Alliance is committed to the success of Jacksonville's youth by ensuring community support and services which emphasize educational achievement, promote the skills necessary to delay pregnancy, and focus on attaining viable personal goals.

The project coordinator went on to ask why teen pregnancy has become a problem? She stated that more than one million teens get pregnant every year in the United States. Teens who get pregnant are less likely to graduate high school. As a result, they are less likely to get good jobs. Their infants are more likely to be sick or have health problems.

The project coordinator stated further that the Jacksonville Alliance wanted to make sure that every young person had an "opportunity to live out our vision." She added that not every teen parent will always live in poverty or will be a school drop out, but that a teen parent is less likely to reach his/her full potential.

In concluding the Teens Orientation session, the project coordinator informed the teens that they are already members of the Teens committee. She reminded them that

they could join one or more of the other committees of the Jacksonville Alliance. She formally invited them to attend the next general meeting of the Jacksonville Alliance scheduled for September 25, 1996.

The Fifth General Coalition Meeting of the Jacksonville Alliance

On September 25, 1996 the fifth general meeting of the Jacksonville Alliance was held at FCCJ Urban Resource Center at 5:50 p.m. Fifty members and one teen and project staff attended this meeting. Members received the following informational items: an agenda, meeting feedback survey, Parents and Community committee flyer, Social Services committee survey for social services providers, Pregnant and Parenting Teens committee description, Religious Community committee report, adolescent pregnancy prevention literature, and "Getting Results and Knowing It," prepared for the United Way of Northeast Florida by the Jacksonville Community Council Inc.

The project coordinator thanked everyone for attending and introduced Mr. Q, State Attorney for the State Attorney's Office in Jacksonville who was to make the opening remarks. Briefly, he stated that statistical studies show that there is a correlation between teen pregnancy and crime. He commended the Jacksonville Alliance for making a direct impact on crime.

Sector Committee Reports

The meeting agenda moved next to the presentation of sector committee reports of the Jacksonville Alliance. The project coordinator emphasized that the meeting focus was a series of update reports on the work of the nine sector committees of the Jacksonville Alliance. She introduced each committee chair, and each committee chair reported what the committee accomplished during the summer. Committee chairs presented finalized goals and objectives. The general coalition body reviewed the work

status of sector committees. A presentation of each sector activity review is presented now.

The view of the business/civic committee

The chair of the Business/Civic community stated the goals and objectives of his committee. He stated that the vision of the committee was to have a menu of programs from which different businesses can choose. The programs were to be the products of the entire Jacksonville Alliance.

He explained that while the coalition was creating programs, the Business committee would try to understand the nature of programs that have been successfully implemented by businesses in other areas. His committee also explicitly requested funding from the CDC grant to accomplish secondary research to identify adolescent pregnancy prevention programs that businesses have supported. He stated that the Business/Civic committee must approach businesses with a well-constructed approach to the issue of adolescent pregnancy that rationalizes the programs from a business perspective.

The view of the education committee

The Education committee chair explained that her committee wanted to support the Health Department of the Duval County Schools since two individuals who were responsible for the implementation of the new health and sexuality curriculum staffed it. The committee decided to survey the teachers who were responsible for teaching the new curriculum. The purpose of the survey was to identify any gaps in support, services, and training needs of the teachers. The Education committee informed the Health Department of Duval County Schools of the committee's plan. The Education committee chair pointed out however, that on September 18th, the project coordinator for the

Jacksonville Alliance received a call from the staff of the Duval County Schools Health Department requesting that the Education committee not send out the survey. The staff of the Duval County Schools Health Department told the project coordinator that perhaps the Education committee could mail the survey in the fall of 1997. Therefore, the staff of the Health Department of Duval County Schools and teachers would have enough time to implement the curriculum. The Education committee chair stated that since the committee could not implement their primary goal, members would have to revisit its other goals.

The view of the government/law committee

The chair of the Government/Law committee explained that initially her committee had decided to pursue the enactment of new laws that would include stronger penalties for adults who had sex with minors. However, after committee members spoke with legislators, the consensus of the committee was that current laws were sufficient. The committee decided to use the existing laws to effect changes in adult/minor sexual relationships (e.g., workshops for educators and social service professionals). She read the goals of the committee, and reviewed on several transparencies the extant laws on lewd and lascivious behavior.

The view of the health and medical committee

A representative from the Health and Medical committee (the committee chair was not present) stated that a delegation from the committee went to West Palm, Florida to visit a Teen Time Clinic. Organization XYZ and other providers such doctors in private practice support the West Palm clinic. Plans were being made to start a teen clinic in Jacksonville. The speaker for the committee stated that money had been approved from the CDC grant to bring a health care performance consultant to facilitate the process. The

committee still needed to determine whether to focus on family planning or on all adolescent health (e.g., acne, digestive disorders).

The view of the media committee

The Media Committee chair stated that her committee chose May as Teen Pregnancy Prevention Month. May was chosen because of the lack of community activity in this month except for school prom events. The committee decided to focus their media activities on parents and not teens. The committee met with three groups within the media community, and expects that they will be able to provide technical support for Teen Pregnancy Prevention Month.

The chair of the Media committee then detailed its view of the needs for the Jacksonville Alliance:

1. Identify a consistent message of what the Jacksonville Alliance is – image
2. Establish a line of communication to speak to various publics
3. Promote events that are newsworthy
4. Separate the image of the Jacksonville Alliance from the government (i.e., Duval County Health Department) in becoming a 501c organization.

The view of the parents and community committee

The Parents and Community committee chair stated that when the committee was formed it did not have a committee chair. She did not start working with the committee until July when she volunteered to become the committee chair. She stressed repeatedly how parents are the critical variable in addressing and solving the teenage pregnancy problem. She spoke about low parental attendance at the Parents and Community meetings and the need to incorporate parents in coalition building. She read the overall goals and objectives of the committee. She announced that the committee was planning

an "open house" on October 30, 1996 to let people know that the Jacksonville Alliance is a community partnership, and not just for social service providers. The Parents and Community chair added that her committee wanted to survey parents and from these results plans would be made for a Parents Workshop in May 1997.

The view of the religious community committee

The Religious Community chair referred everyone to the handout for her committee. She stated that a committee membership drive was implemented in July. She read the goals, objectives, and action steps that the committee had recommended. The Religious Community chair announced that her committee would collaborate with the Jacksonville Community Council Inc. (JCCI) Religious Implementation committee in doing a special workshop in the future. As chair of the Religious Community committee, she stated that she had participated in meetings held by Education, Media, and Teens committees. She pointed out that she planned to visit other sector committees.

The view of the social services committee

The Social Services committee chair reviewed the goals and objectives of her committee. She stated that a survey to collect information for a resource directory would be sent to social service providers, and she invited everyone in the Jacksonville Alliance to fill it out and return it to the project coordinator. The committee chair also emphasized that a special location as well as donations were needed for a lending library on relevant teen pregnancy topics. She said materials that were needed for the lending library should focus on healthy relationships and planning for the future.

The committee chair indicated further that her committee attempted to define teen pregnancy prevention. The committee found that this task was very difficult to

accomplish. The committee finally concluded that anything positive that an adult does with a teen is teen pregnancy prevention.

The view of the teens committee

The chair of the Teens committee went over the goals and objectives of his committee. He emphasized the need to get teens involved in every committee, and he encouraged the other sector committees to make their meetings accessible to teens (e.g., centrally located, after-school meetings).

He stated that teens from participating social services agencies within the Jacksonville Alliance were invited to attend a special meeting of the Teens committee in July. He noted that teens were invited to participate in a Teens Orientation held in September at DCHD. At that time teens learned about the structure and purpose of each committee, and were encouraged to join committees.

Future Directions of the Jacksonville Alliance

The project coordinator concluded the Jacksonville Alliance meeting, stating that goals developed in each committee should build upon the strengths represented in that community sector area. She went on to summarize commonalities within the sector committees.

She noted that raising awareness of teen pregnancy was the underlying thread in many of the committees (e.g., Media Business/Civic, Government/Law, Parents and Community, Social Services, and Education). Likewise, she stated that coordinating services was the key focus of other committees (e.g., Social Services, Religious, Health and Medical, Business/Civic, and Education). Some committees (e.g., Media, Teens, and Parents and Community) she continued were focused on involving the community (i.e., parents and teens in general, not necessarily from a geographic area).

She emphasized that it was up to the Jacksonville Alliance to decide where it was going. Lastly, since the previous general coalition meeting on June 27, 1996, the project coordinator announced that the survey response to add a Pregnant and Parenting Committee was overwhelming. She referred everyone to the committee description that was included in their handouts, and she invited members to join this committee.

In concluding the meeting, the project grant manager announced to the coalition that the project coordinator had decided to leave the project staff at DCHD, and to return working full time for a member organization within the Jacksonville Alliance. The project grant manager publicly thanked the project coordinator for her outstanding contribution to the Jacksonville Alliance.

The project coordinator had been involved in the CDC-funded grant program before the formation of the Jacksonville Alliance. As of the date of her departure on September 30, 1996, the DCHD did not have a replacement for her. September 30, 1996 also was the last day of the first year of Phase I for the CDC "Community Coalition Partnership Programs for the Prevention of Teen Pregnancy" in Jacksonville.

Summary

This chapter used a chronological framework to depict the happenings of the Jacksonville Alliance and the process of community coalition development. The first four stages of development of the Jacksonville Alliance were documented: 1) formal start-up of the Jacksonville Alliance, 2) establishment of organizational structure, 3) building capacity for action, and 4) the need to plan for action. The tasks that were undertaken during the first five rounds of committee meetings and five general meetings of the Jacksonville Alliance were described in detail.

All data, observational and documentary, have been presented within the context of four research questions: 1) How did the community coalition come into existence? 2) How did the community coalition establish its organizational structure? 3) How did the community coalition increase its ability to act? 4) How did the community coalition plan for action? These four research questions directly corresponded to the first four stages of coalition development.

In the next chapter, the data chronology presented in this chapter and buttressed in the appendices, are interpreted in light of the conceptual model of Florin et al. (1993). It is hoped that this discussion of the findings will enable the reader to better understand the complexity of the Jacksonville Alliance as a newly created coalition. The assumptions, strengths, and weaknesses of the Jacksonville Alliance will be elucidated within the context of the pertinent theoretical approaches to the study of community coalitions and as an organizing model in the development of public health interventions.

CHAPTER 6
DISCUSSION

Overall, the Centers for Disease Control's Community Coalition Partnership Programs for the Prevention of Teen Pregnancy (i.e., CDC Partnership model) in Jacksonville, Florida did not work out as planned. The CDC Partnership model was not successfully implemented in Jacksonville for several reasons: 1) a paradigm shift from the traditional human service model to a partnership model did not occur within the Jacksonville Alliance of service agencies, 2) unabated fragmentation between the agencies within the Jacksonville Alliance was present, and 3) the goal of sustained service partnering for teen pregnancy prevention between the Jacksonville Alliance and a community segment targeted to benefit from this effort was not reached.

The stated purpose of a fully activated CDC Partnership model project was to demonstrate that community service partners could mobilize and organize community resources in support of special programs to prevent teen pregnancies. The CDC Partnership model involved partnering at three levels. A level is a conceptual area of relationships between parties within the CDC Partnership model. The first level of partnering was to take place between the CDC and the hub organization, - the CDC-sponsored and funded program administrative unit. The second level of partnering was to occur between the hub organization and the community coalition. The third level of partnering was to take place between the community coalition and the targeted community.

The proposed successful implementation of the entire CDC Partnership model translated into particular activities that needed to occur at the three partnering levels. At the first level of partnering between the CDC and the hub organization, the CDC was obligated to provide technical assistance through workshops and site visits to the hub organization. Likewise, the hub organization was required to attend at least one technical assistance workshop during the two years of the grant. The hub organization served as the fiscal agent of the CDC grant, and it had to meet all grant requirements (e.g., submit semi-annual reports, collect data for cross-site evaluations).

According to the CDC Partnership model, the second level of partnering between the hub organization and the community coalition required both entities to work together in conducting a needs assessment of the targeted community. The hub organization and the community coalition were to work together to plan interventions for the targeted community. The final product of the collaboration between the hub organization and the community coalition around intervention planning was a community action plan that had to be submitted to the CDC near the end of the initial grant period in July 1997.

At the third level of partnering within the CDC Partnership model, the community coalition was supposed to work with the targeted community through direct or representative participation in identifying needs and strategies to address high teen birth rates. According to CDC Program Announcement 547, the community coalition (along with the hub organization) was to involve teens in a meaningful way to plan for the implementation of teen pregnancy prevention programs.

Figure 6-1 represents a graphical presentation of the three levels within the CDC Partnership model. Within each level, the arrows represent partnering between each

entity. For example, at level one, the CDC partners with DCHD. The arrows are bi-directional and suggest a process of exchange of ideas, activities, and resources.

Level 1	Centers for Disease Control (Funder) ⟺	Duval County Health Department (DCHD) or (Hub organization)
Level 2	Duval County Health Depart. (Hub organization) ⟺	Jacksonville Alliance (Community coalition)
Level 3	Jacksonville Alliance (Community coalition) ⟺	Targeted Community (8 zip codes with highest birth rates)

Figure 6-1 CDC Partnership Model

The CDC Partnership Model Required a Paradigm Shift

The CDC Partnership model required a paradigm shift from a service model to a partnership model (Bass et al. 2001; Florida Tobacco Control Clearinghouse 1999; Kruger 2000; Mizrahi 1999; Poole and Van Hook 1997). Table 6-1 compares the key features of both of these models. While the service model represents the customary and actual state of functioning, the partnership model represents the ideal state, the state that CDC hoped would result from their project funding.

The DCHD and the Jacksonville Alliance had been operating under a traditional service model approach to address teen pregnancy. The DCHD expected to be able to use the CDC grant for direct services when the DCHD's director requested help from the community coalition in deciding how to spend the grant dollars in Jacksonville. As a result, members of the Jacksonville Alliance expected or at least, assumed to receive special CDC dollars to underwrite and implement the proposed teen pregnancy prevention programs.

Technically speaking, the service model implied redistributing resources from the funder (in this case the CDC) to the hub organization (in this case the DCHD) and then to

agencies (in this case members of the Jacksonville Alliance), and then to the recipients of the services (clients of the agencies' programs). Likewise, in the service model, a power relationship had evolved between those redistributing resources and those receiving the resources. That is to say, power was vested in agencies where professionals were held responsible for programs. Professionals were considered the "experts," and they were expected to maintain decision-making authority (Bass et al. 2001). Experts retained power since they had control over the resources to be dispensed. As a rule, external leadership stayed outside of the targeted community, and program planning tended to be reactive and fragmented.

Similarly to other sector committees, for example, the Business/Civic sector committee exemplified an unwillingness to shift from a service model to a partnership model. Thus, committee members were asked by project staff about the committee's efforts to involve African-American businesses located in the targeted community. One committee member replied, " the committee had decided that we would go ahead and plan interventions, and we would ask for African-American businesses for their input after the interventions had been planned." The Business/Civic committee members as a whole seemed to legitimate their behavior by considering themselves to be experts and by exercising external leadership outside of the community.

As a rule, the service model fosters a situation where the agency staff and volunteers answer to the agency, and the agency answers to the funder. The community is excluded from the decision-making process (Kruger 2000). The needs and involvement of different community subcultures tend to be glossed over and even denied. As a result, there prevails limited community involvement and influence.

Table 6-1. The Partnership Paradigm Shift

Service Model ("The Old Ways") 	Partnership Model ("The New Ways")
Holding professionals solely responsible for programs	Creating an atmosphere of mutual responsibility
Vesting power in agencies	Sharing power with the community
Relying on professionals as the "experts"	Viewing community members and professionals as having expertise
Fragmented planning	Coordinated planning
External leadership	Shared, community-based leadership
Denying the needs and involvement of different cultures	Appreciating cultural differences and involving varied ethnicities
Excluding the community from the decision-making process	Viewing everyone as a part of the decision-making process
A situation in which staff and volunteers answer to the agency and the agency answers to its funders	A situation in which everyone answers to the community
Limited community involvement and influence	Maximum community involvement

Source: Adapted from Guide to Creating Community Partnerships (Florida Tobacco Control 1999).

Under the partnership model (Poole and Van Hook 1997), the CDC expected the DCHD and the Jacksonville Alliance to demonstrate that community partners could mobilize and organize community resources. Such mobilization required organizational commitment by community coalition members to partner to share their resources (e.g., financial, human) to implement teen pregnancy prevention programs.

Contrary to what the members of the Jacksonville Alliance expected, the CDC grant dollars were not to be used for direct services. According to the CDC (1995), grant dollars were to

- support the efforts of the hub organization to enhance its capacity to strengthen and evaluate the effectiveness of coalition partnership programs; and to
- develop a community action plan for implementing comprehensive community programs to prevent initial and repeat teen pregnancies.

The partnership model involves reciprocity and mutual obligation between the hub organization (in this case the DCHD), community coalition (in this case the Jacksonville Alliance), and the community (in this case the targeted community). Unlike the service model, the partnership model stresses power sharing with the target community.

Another feature that is required of the paradigm shift to the partnership model is that both community members and professionals are viewed as having expertise. The focus is on acting in a joint and unified fashion (Fawcett et al. 1995; Kang 1995). As a result, planning is expected to be proactive, all problem solving is to be focused, as well as coordinated.

Community-based leadership is shared with external leadership. The partnership model is supposed to foster a situation where all involved answer to the "community." In the partnership model, community members are viewed as part of the decision-making process. Restated, all members contribute with the expectation of reaching consensus.

Speaking in general, the partnership model is conceived to engender a cultural theme of collaboration: cultural differences are appreciated and all ethnic groups are welcomed as contributing to a successful mission outcome. Thus, the range of types of people involved is more extensive. It is also generally agreed that the basic cement of a working partnership is trust: there is confidence in the integrity of parties to uphold informal and formal agreements. Mutual respect for and contribution of capabilities by the involved parties, along with their willingness to work together to achieve shared goals are also posited as essential underlying elements of a full partnership (Kang 1995).

The ethnographic chronology showed that a paradigm shift from the service model to the partnership model did not occur in Jacksonville, Florida for several reasons. First,

Jacksonville Alliance members expected that CDC dollars could be allocated and used for direct services. When they discovered otherwise, it became a disincentive for members to work collectively to mobilize resources to develop teen pregnancy prevention programs.

Second, the DCHD and the Jacksonville Alliance were unwilling to shift the power dynamics in program planning in Jacksonville, Florida. Social service providers and other professionals (e.g., health, medical) were used to controlling resources, rather than collaborating with the recipients of their professional services. Moreover, professional sector coalition members were not accustomed to working and sharing power with residents of the project-targeted community, particularly since residents were not within their agency service delivery area.

Third, there did not develop a meaningful opportunity to establish mutual trust and respect between the Jacksonville Alliance and the targeted community. There was no palpable, i.e., observable on-site interaction during the entire time frame of this 12 month field study segment. Instead, coalition members engaged in "blaming the victim," i.e., the targeted community residents, at committee meetings. An example of this was seen at the second committee meeting of the Business/Civic committee. In the process of identifying barriers, members stated that parents did not take responsibility for their children's behavior. It was also pointed out that some parents lacked basic parenting skills: "parents did not know what was 'normal' adolescent behavior." In a similar vein to the Business/Civic committee, members of the Parents and Community committee blamed target community parents. During their second sector committee meeting, Parents and Community committee members openly discussed the lack of parental

involvement. An atmosphere of mutual responsibility was not established, and hence problem solving was inhibited.

Fragmentation Within the Jacksonville Alliance

Independent of any potential for a paradigm shift, structural fragmentation was present at the formation and follow-up activities of the overall community coalition. Fragmentation is generally referred to as a "broken," "disconnected," or "incomplete" organizational state. The cultural theme of the existence of fragmentation of functioning is supported by observed and documentary structural, behavioral, and ideological evidence. This phenomenon is discussed in detail on the basis of applying the first four stages of the Florin et al (1993) coalition development model. As stated previously, this has been the practical conceptual framework for chronicling the corpus of ethnographic data collection.

Florin's Stage 1: Start-up of the Jacksonville Alliance

Even during the initial mobilization of the community coalition, there was structural evidence that the Jacksonville Alliance was fragmented. Proponents of the community coalition literature argued that coalitions provide an avenue for recruiting participants from diverse constituencies, such as political, business, human service, social and religious groups, as well as less organized groups and individuals (Butterfoss et al. 1993; Kegler et al. 1998). Likewise, it has been stated that when citizen participation by disenfranchised high-risk groups is fostered by the community coalition approach, "community ownership of programming" occurs (Florin et al. 1993; Nezlek and Galano 1993).

In actual practice, full citizen participation did not happen in the Jacksonville Alliance. While professionals were invited to participate, residents from the targeted

community were not invited to participate in the initial meetings of the community coalition. As such, the "Jacksonville community" was fragmented from the very beginning.

Moreover, the observed and recorded recruitment efforts carried out by the hub organization revealed that the Jacksonville "community" was not functioning as an unified integrated whole. In fact, it was composed of many parts containing separate "ideologies" (Becker and Dluhy 1998; Schwartz 1981). In reality, the composition of the Jacksonville Alliance defined who was 'included in' and who was 'excluded out' from membership (CDC 1997).

This study also uncovered considerable behavioral evidence of fragmentation. In general, members of the Jacksonville Alliance attempted to engage in intervention planning for the entire Jacksonville community rather than for the targeted zip codes. Coalition members treated the City of Jacksonville as a community of the whole. Members ignored the reality that Jacksonville like all metropolitan areas has many communities (McMillan and Chavis 1986) within its boundaries.

There was ideological evidence of fragmentation as well. There were widely divergent conceptualizations of community in Jacksonville. The sector community coalition membership as a whole did not identify with what Suttles (1972) and Valentine (1978) described as the targeted "geographical"/"territorial" community. This happened despite the fact that the targeted community was supposed to be the focus of the intervention planning for the teen pregnancy prevention programs. Unlike the CDC's conceptualization of community, the Jacksonville Alliance conceptualization of

community remained specific agency related and based on the socio-political nature of program planning among professionals from different community sector areas.

Furthermore, the ethnographic chronology of events showed that the Jacksonville Alliance did not have a palpable direct relationship with the targeted community. The targeted community remained largely an abstract concept with which no sector committee member could identify with personally and directly. A few sector members only interacted with the targeted community based on their particular pre-existing agency-defined function, rather than on their sector related activity-to-be.

Clearly, the pervasive fragmentation that existed in the conceptualization of community conflicted with the underlying principle on which the community coalition model rests. The Jacksonville Alliance was unable to approximate the theoretical and practical inclusive framework of a community coalition, and seek diverse viewpoints as detailed by Butterfoss et al 1993; Fawcett et al. 1997; Florin et al. 1993; and Francisco et al. 1993. The opposite turned out to be true for the Jacksonville Alliance.

Restated, in practice, the Jacksonville Alliance did not insure that everyone in the community was able to participate, and there was no change in behavior. Planning processes remained unchanged. Values remained the same. There was a lack of trust and respect for the targeted community. No collaboration or partnering arose.

Florin's Stage 2: The Need to Establish Organizational Structure

In the course of establishing the organizational structure of the Jacksonville Alliance, there was pre-existing structural evidence of fragmentation. Indeed, a new coalition was created, rather than trying to revitalize a pre-existing coalition structure, 'First Coast Adolescent Health Consortium' (FCAHC). Sector committees of the

Jacksonville Alliance were comprised of mostly self-contained activity segments of the broader society (e.g., religious, business/civic, media, medical).

In this stage of the coalition development, behavioral evidence exists to support the cultural theme of fragmentation. As in the larger American society, members worked and interacted primarily, if not preferentially within their occupational areas of expertise. There was no integration across committee structure, no cross-sector linkages, during the first nine months of the Jacksonville Alliance. The Jacksonville Alliance did not change how people from different sectors interacted with each other. Sporadic, perhaps haphazard efforts at involving different types of people in decision-making did not seem to motivate the entire body of sector committee members to work together.

Ideological evidence of fragmentation during the Jacksonville Alliance stage of establishing organizational structure has already been noted. Coalition members approached teen pregnancy through their occupational viewpoint. As a general rule, committee members discussed teen pregnancy only from the interest of their community sector. For example, Health and Medical committee members focused on creating a network of "teen clinics" in making medical services accessible to teens. In their agency-nested proposed intervention, the emphasis was on reproductive health issues. They did not incorporate other sector activity perspectives from, for instance, business, clergy, and media.

Florin's Stage 3: The Need to Build Capacity for Action

During this stage, the cultural theme of fragmentation continued to be evident. Structurally, the DCHD did not strengthen coalition members' capacity to respond to teen pregnancy in the targeted areas where birth rates were the highest. Likewise, coalition members as a whole did not receive or gather new first hand information about how to

address teen pregnancy in the targeted community. The reality that there were cultural differences between them and the targeted community remained in the closet. For example, coalition members continued to plan for the overall community even though at the second general coalition meeting in March 1996, the guest speaker, Dr.X, a nationally recognized speaker on adolescent pregnancy prevention programs, advised a paramount focus on teens with a specific demographic profile. While understanding the realities of out of wedlock births among white teens, she declared confidently:

> "You don't have to focus on the white teenage girl. You don't have to worry about her. Her white middle-class mother will make sure that she doesn't get pregnant or have a baby. Who you have to focus on is the teen girl who lives in the housing projects. That's where you need to focus your attention. The most successful child/parent programs work best in the projects."

Behavioral evidence to support fragmentation in this stage suggests that even with the plethora of informational documents and verbal statements available to the Jacksonville Alliance coalition, its members did not collectively discuss the information that was presented to them. As a consequence, coalition members from the different sectors were not ready to develop a well-reasoned coalition approach to addressing teen pregnancy prevention in Jacksonville.

It is recognized that community coalition members have different ideologies, resources and maintenance needs (Butterfoss et al. 1993). This was amply evident in this ethnological study. Not every coalition member had the same level of understanding of teen pregnancy issues. In trying to build capacity for action, the DCHD provided guest speakers and a raft of pertinent literature at community coalition meetings to create awareness about the teen pregnancy problem at the local, state, and national levels.

In general, members of the Jacksonville Alliance held uniformist assumptions that teen pregnancy issues were the same throughout Jacksonville. Despite the diversity of

life ways that prevails within Jacksonville, coalition members in examining their preconception of the problem showed no interest in CDC's request for a separate, new needs assessment of the targeted community during the CDC's first site visit in March 1996. At this stage of coalition development, their differing viewpoint from the CDC corroborates the pervasive organizational cultural phenomenon of fragmentation.

In addition to not having a needs assessment, no baseline data were collected on the intended recipients of the coalition's intervention. Moreover, the data chronology shows that neither the DCHD nor the coalition had mechanisms in place to measure whether its efforts had any impact on teen birth rates. Restated, there existed no model in place to measure program success based on outcomes.

Florin's Stage 4: The Need to Plan for Action

In planning for the action stage of coalition development, there was compounding structural evidence to point out organizational fragmentation of effort. This became apparent first in the turnover rate of the principal program staff at the DCHD. Indeed, between the first coalition meeting in January 1996 and the third coalition meeting held in May 1996, a rift developed between the second grant manager, the principal investigator, and project coordinator. We recall that the first project grant manager resigned after the initial coalition meeting.

In March 1996, the CDC staff, at their first site visit to Jacksonville, suggested the project staff undergo a well-organized team-building process. Rather than following through on this recommendation, several weeks after the CDC site visit, the second grant manager and the principal investigator resigned.

There are many kinds of behavioral evidence that fragmentation in program efforts persisted throughout the planning for action stage. Blaming the victims, particularly,

teens and parents did not promote problem solving to be sure. It precluded collaboration between coalition members and with those that they were supposed to serve. Committees spent repeated meeting rounds identifying strengths, barriers, goals, and objectives based on their own primary community sector areas. It became more and more evident in committee meetings that members tried to blame other sectors for existing difficulties to get "the show on the road," so to speak. "They seemed to prefer to dwell on identifying barriers/deficits that existed in various community sectors.

During committee meetings, members generated long lists of generalities that seemed to further inaction in developing operational teen pregnancy prevention programs. Focusing on "generalities" and not on "specifics" such as condom distribution versus abstinence-only/abstinence-based issues prevented the Jacksonville Alliance from taking a definitive, visible, and audible position on teen pregnancy prevention.

The research of Nelzek and Galano (1993:442) noted that as coalitions move from the easy agreement that typically accompanied the broad and vague initial goals to more delineated positions concerning specific issues, disagreements tend to move into the foreground. The behavior of committee members made it seem that choosing to standby and defend a particular position would dissolve the public relation appearance of cohesion and unity within the Jacksonville Alliance. Moreover, it would have dramatized the underlying fragmentation within the coalition. Instead, the coalition maintained itself in a state of "cognitive dissonance" by avoiding airing internal value and behavioral conflicts, and thereby stagnating the creation of specific intervention programs for teens. Speaking in general at this junction, "process," - developing sector-based goals and

objectives, - became more important than working on a "product," - effective teen intervention programs.

Further behavioral evidence that fragmentation persisted throughout the nine months of the coalition is the fact that sector committee goals and objectives were never integrated within overarching coalition goals and objectives. Committees developed their own goals and objectives based on their community sector (e.g., education, media). Sector committee goals and objectives were supposed to represent the overall goals and objectives of the coalition. In this ethnographic chronology, overall coalition goals and objectives were never identified at the general coalition meetings.

Even interest in furthering the coalition process faltered as meeting attendance declined. Both the Business/Civic and Parents and Community committees cancelled scheduled meetings twice due to low attendance.

Recorded ideological evidence tended to highlight fragmentation of action during the planning for action stage. There was an expectation by the DCHD staff, especially the project coordinator, that there would be an emerging consensus in the Jacksonville Alliance's approach to addressing teen pregnancy. Nine months after the coalition was formed, at the September 1996 general coalition meeting, it was clear that an emerging consensus had not been achieved.

For example, at the September 1996 meeting, the chair of the Business/Civic sector committee stated while the coalition was creating programs, the Business/Civic committee would try to understand the nature of programs that had been successfully implemented by businesses in other areas. He argued that the Business/Civic committee must approach businesses enterprise with a well-constructed approach to the issue of

adolescent pregnancy, an approach that rationalizes the programs from a "business perspective." His statement reflected concerns expressed by Business/Civic committee members about whether to create new programs or stick with and support already existing teen pregnancy prevention programs.

Similarly, at the same September coalition meeting, the chair of the Media sector committee expressed concern over the lack of a public image for the Jacksonville Alliance. She added that the image of the Jacksonville Alliance needed to be separated from the primary, fiscally responsible government agency, - the DCHD. These kinds of public statements underscore the differences in interest and focus within the coalition.

Lack Of Partnering Between The Jacksonville Alliance And The Targeted Community

Fragmented action within the Jacksonville Alliance mirrored the lack of coalition building that existed between the coalition and the targeted areas. Within the three tiers of the previously outlined CDC Partnership model, partnering between the Jacksonville Alliance and the targeted community was not detectable. To reiterate, partnering behavior refers to interaction in the context of a formal or informal relationship between at least two entities to achieve a common goal.

From January to September 1996, the issue of coalition building through community outreach in the specified targeted zip codes was an issue that did not appear to be a priority either for the DCHD or for the Jacksonville Alliance. Despite the CDC's recommendation to engage in community outreach efforts during a site visit in March 1996, parents and teens from the targeted zip codes were not incorporated thereafter into coalition building efforts. As a result, in May 1996, it was necessary to arrange for a change in my job description from "community specialist" to "process evaluator" from the DCHD director. We recall that in May 1996, the project coordinator stated that she

had no plans for the Jacksonville Alliance to engage in community outreach in the targeted zip codes.

During the entire ethnographic study period reported on here in, there was no formal or organized strategic interaction between the Jacksonville Alliance and the targeted community through direct or representative participation such as neighborhood crime-watch groups, parent-teacher associations. The efforts to recruit teens and parents remained marginalized into the Teens committee and the Parents and Community committee. Integrated recruitment efforts by all sector committees and the general membership of the Jacksonville Alliance were never established.

Furthermore, throughout the first nine months of the coalition's existence, the Teens sector committee solicited teen participation on the Jacksonville Alliance without its connection to residency in targeted zip codes. Likewise, in the Parents and Community sector committee, there was no recruitment of parents and community members from the targeted areas to participate on this committee by DCHD or the Jacksonville Alliance.

The Parents and Community sector committee experienced notably low meeting attendance and little leadership. Months after the appointment of sector committee chairs in February and March 1996, in July 1996, a volunteer joined the group and agreed to serve as chair of the Parents and Community committee. During the September 1996 coalition meeting, she emphasized the need to incorporate parents in coalition building. Optimistically, with the leadership of this new chair, the Parents and Community sector committee planned to have an Open House on October 30, 1996 to let people know that

the Jacksonville Alliance was a community partnership, and not just for social service providers.

Reciprocity and Coalescence: Fundamental Processes To Improve Community Coalition Partnerships

The discussion now moves to a formal consideration of reciprocity and coalescence, fundamental processes thought to improve community coalition partnerships. Having documented and discussed the various reasons why the CDC Partnership model was not successfully implemented in Jacksonville, the question arises how can community coalitions avoid pervasive fragmentation? Reciprocity and coalescence were two necessary processes that have been advocated and tried in reducing fragmentation within community coalitions in other settings. Antithetical to fragmentation, reciprocity and coalescence have been recognized as integrative cultural processes.

In this ethnographic research, cultural processes include behavioral "mores" and shared "mind-sets." It is not enough to focus on the structural dimension of a community coalition as seen in the literature on community coalition development (Butterfoss et al. 1993; Fawcett et al. 1997; Florin et al. 1993). This research demonstrates that the effectiveness of a community coalition partnership is dependent upon the development of reciprocity and coalescence.

According to Mizrahi (1999), successful organizational collaboration is based on reciprocity. As cited in the anthropological literature (Chagnon 1992; Sahlins 1972; Stack 1974), "balanced reciprocity" is defined as a mutual economic and/or social exchange. In essence, this type of reciprocity indicates a relation in which one act or thing balances or is given in return for another.

In an effective community coalition, one that fulfills its goals by making an impact on the issue(s) that it set out to address, "coalescence" is a complementary process that serves as the "glue" in coalition building. Although very little is written about coalescence (Blum and Ragab 1985), in the literature on community coalitions, Butterfoss et al. (1993:316), have stated that the word 'coalition' itself, is derived from two Latin roots, *coalescere*, 'to grow together,' and *coalitio*, ' a union.'

Coalescence is thought to happen when agency partners unite structurally, behaviorally, and ideologically on behalf of a community coalition. That is, the partners work for a common end. The process of coalescence is conceived to facilitate a shift from only advocating on behalf of a member organization to advocating on behalf of the goals and objectives of the all the partners in a formal community coalition.

In this ethnographic chronology of the Jacksonville Alliance, the processes of reciprocity and coalescence were rarely observable. However, when these processes were noticeable, fragmentation was abated for those involved. A few incidents where reciprocity and coalescence were present serve as an example.

Members of the Government/Law sector committee worked well together and even met with state lawmakers to identify committee goals that were achievable. As representatives of organizations such as the State Attorney's Office, with interests in informing the public, - especially educators, social workers, teens, and parents - about the legal ramifications of adult-minor sexual relationships, members of the Government/Law committee were able to fulfill professional obligations, and provide an intervention that benefited both coalition members, and non-coalition members (e.g., teens, and parents who were not involved in the Jacksonville Alliance). Subsequent to this reported 12-

month chronology, between 1997 and 1999 the Government/Law committee collaborated with the Social Services committee to sponsor workshops on adult-minor sexual relationships for social service providers and educators. During that period of time, the Government/Law committee also worked with the Teens committee to sponsor "teen skits" (i.e., short messages portrayed by teen actors) about adult-minor sexual relationships.

Thus, reciprocity and coalescence can be viewed as distinctive, fundamental processes that help organizational inaction and fragmentation. Participant observation and a review of documentation also clarified the organizational principle that a community coalition is more than the sum of its parts; indeed, its essence lies in the interaction among the parts. The processes of reciprocity and coalescence involved cross-sector committee integration within the coalition partnership and involvement with the community.

There has been an assumption noted in the literature (Blum and Ragab 1985; Mizrahi 1999) that is also documented in by the actions of project staff, that the coalescence process could eventually take place in the Jacksonville project. However, this did not really happen in the Jacksonville Alliance. The question looms large: What ideological and structural incentives have to be present to encourage people to work together?

Both ideological incentives and structural incentives to beneficent action are based on reciprocity. Thus, organizational membership implies belief that there will be some tangible benefit from participating in a coalition (Bodo et al. 1991). CDC had unrealistic expectations that the component or sector organizations (e.g., social service, businesses

and denominational) in the Jacksonville Alliance would mobilize community resources to address teen pregnancy without financial benefits in return. Every CDC dollars flowed into the hub organization, the DCHD. It was not authorized to distribute monies for direct services. There were no mechanisms in place for reciprocity between the second and third levels of partnering within the CDC Partnership model: "Organizational self-interest is legitimate, and there is a saying among organizers that "Groups join coalitions to gain power, not to give it away" (Bodo et al. 1991:73).

In the Jacksonville Alliance, the putative partners were never asked what they wanted to gain for their participation. Ideally, ideological incentives for professionals and residents can include but are not limited to any of the following particulars:

- The opportunity for teens to better their future by delaying pregnancy.
- The opportunity for teens to do community service (i.e., participating in the community coalition) that may lead to references/recommendations for jobs/college admission.
- The opportunity for teens to develop leadership skills and meet other people.
- The promotion of leadership among teens recruited by the coalition.
- Understanding different viewpoints.
- Validating the culture of residents (e.g., acknowledging assets such as 'wisdom-wit' passed through elders/leaders within their community), and the culture of professionals.
- The opportunity for professionals to help others and to work with volunteers with similar mindsets.
- The opportunity for professionals to interact and influence (e.g., mentor) teens.
- The opportunity for professionals and residents to work together on a common goal.

Structural incentives for professionals and residents that come to my mind and that can be implemented include but are not limited to:

Easy to implement

- Listing community service on a resume.
- Creating opportunity to socialize after meetings by providing food/snacks.

More difficult to implement

- The opportunity for networking with other organizations.
- Enhancing group functioning through skill building and training workshops on team building, conflict resolution, leadership training, and intercultural communication.
- Hiring and/or appointing people to follow-up with participants, and to inform them about future meetings/activities.
- The opportunity to present others with information about the coalition (e.g., member organizations).
- Soliciting input from teens, and recruiting teens to participate on different committees.

Difficult to implement

- The selection of more appropriate members (e.g., professionals who want to work with community residents)
- The opportunity to do "pro-bono" work.
- The opportunity to impact teens by creating a scholarship fund that acknowledges their organization's contribution.
- The opportunity to identify and develop criteria to determine when and how members should receive public recognition and rewards.
- Giving grant(s) to agencies that work with residents to expand their agencies' services in the targeted area(s).
- Finding meeting locations and times that are agreeable to both residents and professionals.
- Hiring community liaisons and community organizers.
- Hiring experienced staff (e.g., administration, evaluation).

Additional Features To Improve Community Coalition Partnerships

Given the complexity of coalition formation, we need to address several additional fundamental and operational features that play a role in promoting community coalition partnerships. According to Kegler (1995), factors that influence the success of community coalition partnerships tend to vary in light of the contextual environments in which they operate. Based on this study's data on the formation and initial functioning of the Jacksonville Alliance, certain conditions seem important to improve a community coalition partnership. According to the literature previously cited, and my own observation, the following fundamental features of seemingly equal significance can improve a community coalition partnership. This heuristic enumeration includes: 1) a clear and shared purpose, 2) an integrated approach to solving community health issues (e.g., a teen pregnancy strategy that will integrate all partnership efforts), 3) realistic coalition goals and objectives, 4) a clear understanding of funding requirements to support the coalition and interventions, 5) identification of the end users of the interventions (i.e., the target market), and 6) organizational commitment by coalition members.

A Proposal for an Alternative Model of Coalition Development

As stated before, community coalitions progress through various developmental stages in their organizational lifecycle. Research findings on the Jacksonville Alliance demonstrated the need to reformulate the dimensions of the extant community coalition development model. We recall that Florin et al. (1993) and similar models (Butterfoss et al. 1993; Fawcett et al. 1997) emphasized structure. The proposed model for coalition development provides an internal shift in the framework for understanding the behavioral dynamics as well as the structure of a community coalition.

In particular, the proposed model focuses on two key cultural "dynamics," that is to say, socio-behavioral mores and shared mind-sets – processes, namely reciprocity and coalescence. These cultural features are clearly linked to the structural dimension of organization formation that dominates the previous coalition development models.

Six stages in the coalition development process in a newly formed community coalition are suggested: 1) formation, 2) needs and assets assessment, 3) identity development, 4) organizational structure, 5) intervention development, and 6) maintenance. This Reciprocity and Coalescence Model is compared with the Structural Model of Florin et al. (1993) in Table 6-2. To simplify discussion, only the first four stages of Florin et al. (1993) model are listed for comparative purposes. The other stages are outside of the purview of this study. In chapter 2, a complete listing of the stages of the coalition development model of Florin et al. (1993) has been presented.

Table 6-2. Comparison of Two Models of Coalition Development

Structural Model by Stage (Florin et al. 1993)	Reciprocity and Coalescence Model by Stage (Proposed)
Initial mobilization	Formation
----------	Needs and Assets Assessment
----------	Identity Development
Establishing organizational structure	Organizational Structure
Building capacity for action	Intervention Development
Planning for action	Maintenance

Between and within each stage of coalition development, reciprocity and coalescence can be fostered through ideological and structural incentives to create a sense of united purpose among coalition participants. Since organizational and individual coalition members are diverse in terms of their skills, expertise, and other factors, reciprocity and coalescence are needed to help coalition members "grow together" and form a united group. By working together on behalf of the coalition's interests, and not

solely the interests of their organizations or special agency interests or agendas, the community coalition seems to become better poised to accomplish its goals.

Like the "initial mobilization" stage in Florin et al. model (1993), the proposed "formation" stage focuses on the recruitment of key community sectors. In the Reciprocity and Coalescence model, however the recipients of the interventions are recruited as a priority task in the formation stage.

In the proposed model, "needs and assets assessment" is a critical stage. It is not just a task as in Florin et al. model (1993). The overarching public health issues must be defined and conceptualized by coalition members and their constituencies. Baseline data must be collected, and in the future linked to outcomes. In assessing needs and assets within the targeted areas, coalition members are able to coalesce – come together, - by validating the culture of the targeted residents population. The physical and symbolic assets present in the targeted areas, and the mind-sets or culture of member organizations such as commitment to community service must be fully recognized by all concerned. Opportunities for reciprocity within and outside a given community coalition can be identified, as assets are linked to meet the identified needs.

"Identity development" which is highlighted in the proposed model is a vital stage in the organizational life course of a community coalition. Although the Jacksonville Alliance formulated vision and mission statements, it did not formulate and prioritize coalition goals and objectives. During the presentation of committees' goals and objectives at the September 1996 coalition meeting, the Media sector committee chair however, advised the membership to develop a consistent image of the Jacksonville Alliance. Her remarks suggest the importance of shaping a clear public identity as an

integral part of its basic tasks. "Identity development," as noted before, is not addressed nor is it assumed in the Florin et al. model (1993).

The "organizational structure" stage is expected to concentrate on the best ways to address selected service interventions and maintenance functions of a community coalition. The "organizational structure" stage in the proposed model is quite similar to the stage indicated in the Florin et al. (1993) model. However, it is anticipated to follow after "identity development" in the proposed Reciprocity and Coalescence Model of Coalition Development.

"Building the capacity for action" in Florin et al. (1993) model is viewed as a discernible action stage. However, the processes of reciprocity and of coalescence encourage coalition members to work together. Reciprocity and coalescence occur between and within each stage. The "intervention development" stage focuses on integration of committee work within the coalition and building organizational commitment to essential human and financial resources for selected interventions. The "maintenance" stage emphasizes the task of securing financial support to meet financial gaps for interventions and to fund coalition operations.

Taking into consideration the literature on community coalitions and this research endeavor prompts the introduction of the new "ideal-typical model," which has been named the Reciprocity and Coalescence Model of Coalition Development. The model's name notes the importance of these two integrative socio-cultural processes. The proposed detail of the processes, stages, and examples of tasks associated with the process and stage in this new ideal-typical model are summarized below in Table 6-3.

Table 6-3. Reciprocity and Coalescence Model of Coalition Development

Processes and stages of coalition development	Examples of tasks associated with processes and stages
Processes of Reciprocity and Coalescence	Select appropriate members. Promote the opportunity for professionals and residents who are interested in the issue and who are willing to work on a common goal.
Stage 1: Formation	Hub organization/community leaders recruit organizations from key community sectors that are involved and/or interested in addressing the public health issues. Hub organization/community leaders recruit community residents from areas where the public health issue is of greatest concern.
Processes of Reciprocity and Coalescence	Validate the culture of residents (e.g., acknowledge assets within their community) and professionals.
Stage 2: Needs and Assets Assessment	Engage coalition members and constituencies to define and conceptualize the public health issue. Involve coalition members and residents in assessing needs and assets in the targeted area as perceived by constituents.
Processes of Reciprocity and Coalescence	Promote the opportunity to present the organization's purpose to others that are not familiar with their work.
Stage 3: Identity Development	Formulate vision and mission statements. Formulate and prioritize coalition goals and objectives within the framework of the results from the needs and assets assessment.
Processes of Reciprocity and Coalescence	Promote the opportunity for professionals to interact and influence (e.g., mentor) teens.
Stage 4: Form Organizational Structure	Coalition members form committees based on selected interventions. Coalition members form committees to support maintenance functions of the community coalition.
Processes of Reciprocity and Coalescence	Give grant(s) to agencies that work with residents to expand their agencies' services in the targeted area(s).
Stage 5: Intervention Development	Intervention committees integrate their work with general coalition membership at general coalition meetings to solidify intervention plans and to obtain letters of organizational commitments of human and financial resources in order to implement interventions.
Processes of Reciprocity and Coalescence	Enhance group functioning through skill building and training workshops on team building, conflict resolution, leadership training, and intercultural communication.
Stage 6: Maintenance	Engage members in grant writing to secure financial support to meet identified financial gaps for interventions, and to fund the operations of the community coalition (e.g., administrative costs such as staffing, mailing).

This presentation remains provisional at present, as it will require a considerable amount of further ethnological research.

To recapitulate the argument, what can be gained through the processes of reciprocity and coalescence? First, a key aspect of the Reciprocity and Coalescence Model of Coalition Development is that the coalition's organizational culture is both acknowledged and negotiated (Brannen and Salk 2000). A culture of community is developed through reciprocity and coalescence. The social organizational ethnography of the initial operation of the Jacksonville Alliance demonstrates that a cultural structure and process are important and necessary for effective coalition development.

Second, the rise of reciprocal action and coalescence create the context for partnering (Maccoby 1997). In general, special partnerships are able to develop within the coalition as a whole and between the coalition and the targeted service delivery areas, and the targeted community. In reality, reciprocity and coalescence are socio-cultural processes that are contributing factors even before the first stage of coalition development. Ideological, structural, and behavioral incentives are needed: 1) to get individuals and organizations to come together as a coalition, and 2) to exchange ideas, goods, services, time, and other resources with other members in order to facilitate the redistribution of resources to achieve the identified overall coalition goals and objectives.

Third, reciprocity tends to facilitate both economic exchange and social exchange among members of the coalition and the targeted community. In the traditional human service model, there is a unidirectional flow of resources from funder to provider to residents. Balance reciprocity, however is bi-directional, even multi-directional, given the number of participants, and it prevents passive acceptance of resources. As a result,

the existence of reciprocal arrangements encourages innovation among coalition and targeted community participants.

As a rule, coalition members do not have unlimited resources of money and time. Exchanging ideas, goods, and services, among coalition members can reduce duplication of services and waste among member organizations. Residents of the targeted areas can be expected to exchange their assets (e.g., expertise in finding solutions to the public health issues, and their time by participating in intervention programs) for particular goods and services offered by coalition member organizations.

Fourth, partnership participation is valued and strengthened through reciprocity. Members participate knowing that they or their organizations will receive something in return. In essence, both the coalition and residents are inter-dependent upon each other in addressing public health issues. In other words, it is not enough to create intervention programs. Both coalition members and residents must participate directly in developing intervention programs if the interventions are to be successful.

Fifth, reciprocity encourages coalescence within the coalition and between the targeted areas. Extant literature documents the reality that reciprocity is at the core of many of the most productive human relationships (Chagnon 1992; Sahlins 1972; Stack 1974; Williams 1995). Coalition members who engage in relationships within the coalition and between the targeted areas are more likely to strengthen their commitment to achieve stated coalition goals.

Sixth, reciprocity and coalescence tends to abate the tendency of fragmentation within a coalition, as well as between a coalition and its targeted areas. As reported frequently in this study, fragmentation was present in the Jacksonville Alliance. An

exception were members of the Government/Law committee who were able to work among themselves, and to collaborate with the Teens committee and the Social Services committee to bring awareness of the legal ramifications of adult-minor sexual relationships.

To conclude this discussion, the processes of reciprocity and coalescence are integrative forces that can mitigate fragmentation. The processes of reciprocity and coalescence promote the ideological, structural, and behavioral incentives needed to encourage partnerships to be formed within the coalition development model. It is suggested that if these processes had become institutionalized, they could have facilitated the successful implementation of the CDC Partnership model in Jacksonville, Florida.

CHAPTER 7
CONCLUSIONS

Summary and Conclusions

This ethnographic study has documented the organizational processes that occurred during the initial life course of a new community coalition. The "classic" ethnographic field study method has proven to be useful in describing and explaining the sequence of actions and the outcomes from the coalition's efforts.

The customary agency-focused service model familiar to coalition members was incompatible with the sponsoring and funding source's intention: to demonstrate the viability and greater effectiveness of a teen health program operating under the principle of partnership between community action sectors and a targeted service population. The chronological ethnography that has been presented showed that the CDC Partnership model could not become a reality for three overriding reasons: (1) a paradigm shift from the service model to a partnership model did not occur within the Jacksonville Alliance, 2) organizational fragmentation of action within the Jacksonville Alliance was pervasive, and 3) a partnering arrangement did not evolve between the Jacksonville Alliance and the targeted community.

In light of the ethnographic findings, this study proposes an alternative "ideal-typical" model for coalition development to counteract fragmentation. The model emphasizes the cultural dynamics of reciprocity and coalescence within the functional structure of community coalition development.

This research contributes to the existing literature in anthropology, health education, community development, and the partnership literature. It is thought to do so by chronologically depicting and explaining the many daunting challenges that occur when coalition members attempt to work together within an organizationally fragmented community. The perhaps discomfiting findings from this research are timely because many federal programs require the establishment of community coalition partnerships as a prerequisite to the receipt of federal funding. Overall, this study demonstrates the need to reexamine the concept of partnering, and the ways in which that concept can be applied in community settings. Without going into more detailed argument, two general conclusions are offered for consideration by the reader:

Conclusion #1

Fragmentation in the Jacksonville Alliance reflects the fragmentation that already existed in the "Jacksonville community," and to varying degrees throughout American society.

Fragmentation within the coalition existed because there was a lack of structural and cultural integration. Most committee members only worked within their health, human service, and economic sector areas. Committee goals prevailed. There were no coalition goals.

Fragmentation of efforts existed because coalition members embraced a service model, while CDC advocated and wished to support a partnership model. Coalition members most of whom were professionals did not work with non-professionals, or laypersons, i.e., residents in the targeted service areas.

During the initial nine months of coalition formation, there was abundant evidence that lack of cohesive action even made the term "community" a misused or irrelevant

term. The different uses of community by the CDC, DCHD, and the Jacksonville Alliance clearly exacerbated the desire to address teen pregnancy in Jacksonville. The CDC defined community by residence, the targeted community. For the DCHD, community represented the sector activity areas such as education, business, government, and health in Jacksonville. The Jacksonville Alliance actually defined community as the overall Jacksonville community, or metropolitan area.

Conclusion #2

There was an inherent conflict over ways to redistribute or reallocate goal-oriented activities to reduce teen pregnancy, and move beyond the traditional human service model in order to align these activities with the CDC Partnership model.

Gradually, the socio-economic exchange of redistribution of assets and talent creates a system of dependency as goods and services are circulated from the giver to the receiver. In every exchange transaction between giver and receiver, a dependency relationship is reinforced and a formal status differential is established in the traditional service model. Resources are redistributed between the funder (in this case the CDC) to the hub organization (in this case the DCHD), the agencies (in this case members of the Jacksonville Alliance), and the targeted recipients of the services (clients of the agencies' programs).

A balanced socio-economic exchange or reciprocity creates a system of interdependency as goods and services are circulated between a giver who receives and a receiver who gives. As a result, participants in the ideal CDC Partnership model gain through win-win transactions, helping the coalition fulfill its overall shared purpose and reach its goals. Accordingly, coalition success depends on the ability of all stakeholders

(e.g., committees, residents, CDC, DCHD) to interact interdependently, sharing their time, expertise, effort, and all other resources pertinent to the tasks at hand.

Some Recommendations For Future Coalition Building

Based on the above research-based conclusions, four recommendations are suggested. Recommendation #1 is an attempt to address conclusion #1, which regards the issue of fragmentation in the "Jacksonville community." The second, third, and fourth recommendations correspond to conclusion #2. These recommendations encourage coalition members to shift from dependent and uni-directional to interdependent, bi-directional relationships of socio-economic partnering and reciprocity.

Recommendation #1

Before forming a community coalition to abate high-risk teen pregnancies, the question of who exactly makes up a "targeted community" must be addressed. Proceeding formally to shape a coalition membership follows. Then, designing the specifics of coalition interventions can begin in earnest.

Recommendation #2

To integrate exchange systems of reciprocity and redistribution in a designated community, interdependent relationships must be established between coalition members and residents so that power is shared in partnering outcomes in both planning and on-site decision-making.

Partnering can occur within a spectrum of participation from low to high intensity. A low level of participation occurs when members and residents attend meetings, but there is more likely to be little interaction; the coalition membership retains preeminent power. A mid-range level of participation tends to occur when coalition members and residents targeted for special programs attend meetings, but residents can only advise and

consent, while coalition members retain the privilege to make and implement all decisions. A high participation level occurs when both coalition members and residents share power to plan and determine how resources are allocated and what services are prioritized.

Recommendation #3

To foster a partnership model, special attention is needed in selecting members in a community coalition.

It is not beneficial to issue blanket invitations to individuals and organizations that are not known to be potentially receptive to working in a partnership role with persons and groups that have been traditionally marginalized or disenfranchised. Before sending invitations to join a community coalition, the project coordinator or designated hub organization staff need to meet with potential coalition members first to discuss their willingness to plan coalition interventions interdependently with residents.

Recommendation #4

To foster reciprocity and coalescence, overarching ideological and structural incentives for professionals and residents must be identified before and during the organizational life course of the community coalition.[1]

Proposed Areas For Future Research

Based on this ethnographic study of a community coalition in Jacksonville, Florida, there are a number of areas meriting future research.

One area for future research is to test the Reciprocity and Coalescence Model of Coalition Development on alternative sites to evaluate its robustness. Modify the model

[1] Suggestions of possible ideological and structural incentives for professionals and residents were identified in Chapter 6.

as appropriate. Moreover, a productive area of investigation is to identify the necessary and sufficient conditions that tend to foster partnering behavior. This would include examining the extent to which coalition member-selection is a critical turning point for success in partnering efforts.

This includes the question of to what extent it is desired by participants to receive personal gain and recognition at professional, or personal and professional levels to motivate them to make a serious partnership effort. This would of course focus on how committed and involved participants have to be and wish to be for the partnership to be successful.

A second area meriting future research is to compare different types of community coalitions (e.g., a new versus a well established coalition) to see how they mature in decision-making and action over time. This would involve looking systematically into the role and relative importance of reciprocity and redistribution, and the implications for coalition effectiveness. The extent to which the organizational age of a coalition is related to the presence and strength of reciprocal arrangements is relevant here.

A third area of needed future research is to explore the role of cultural diversity among sub-cultural groups participating in a coalition and any emerging coalition culture. This kind of investigation would presumably cover possible effects of diversity on processes of integration and effectiveness of organizational works.

APPENDIX A
DOCUMENTATION INSTRUMENT

MEETING NOTES

Name of Meeting _____

Date _____ **Location**_____ **Facilitator**_____

Staff Present _____

Scheduled Time			Actual Time		
Start	Stop	Total Hours	Start	Stop	Total Hours

	Members Present (i.e. Alliance members, guest speakers, etc.)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

	Questions to Consider	Y/N
1	Was the meeting purpose expressed or known by members?	
2	Were the minutes disseminated?	
3	Were the minutes approved?	
4	Is there an agenda?	
5	Did the committee follow the agenda?	
6	Did the committee address most of the items on the agenda?	
7	Was the communication flow multidirectional (i.e. interaction between members)?	
8	Did members take notes?	
9		
10		

	Information Materials Distributed	Housekeeping Details (next mtg time/place

MEETING NOTES

POST MEETING NOTES*	MEETING NOTES
1. How was the meeting time divided between updates and discussion?	
2. What were the main issues addressed in the meeting?	
3. What decisions were made?	
4. How were the decisions made? How much input did the chairs/facilitators have in decisions?	
5. Was there any disagreement? How was it resolved?	
6. How was participation distributed across the group?	
7. Who did not participate much? Any ideas why?	
8. In working sessions, who talked to whom? Any obvious groupings/factions/alliances?	
9. What was the general climate like (relaxed, friendly, formal, rigid, angry, bored)?	
10. What role did the project coordinator play in the meeting?	
11. What role did the chair/facilitator play in the meeting?	
12. What role did the evaluators play in the meeting?	
13. Who came in late or left early? Why?	

*Source: Observation Guide for HEART of OKC Planning Meetings, Developed by Michelle Kegler, Univ of Oklahoma

APPENDIX B
COMPLETED DOCUMENTATION INSTRUMENT

Name of Meeting Staff Meeting
Date April 2, 1996 **Location** Room 214-DCPHU **Facilitator** Dr. V - Director DCPHU → now DCHD
Staff Present See Below

Scheduled Time			Actual Time		
Start	Stop	Total Hours	Start	Stop	Total Hours
10:30	12:00	1.30	10:45	11:25	40 minutes

Members Present (i.e. Alliance members, guest speakers, etc.)	
1	Annette Jones - Project Coordinator
2	Domenico Herrerra - Secretary
3	Rebecca Woods - Research Assistant
4	Dr. V - Director of DCPHU
5	Dr. Y - Medical Anthropologist
6	Dr. W - Project Evaluator
7	myself - Community Specialist
8	
9	
10	

Questions to Consider:		Y/N
1	Was the meeting purpose expressed or known by members?	N
2	Were the minutes disseminated?	N
3	Were the minutes approved?	—
4	Is there an agenda?	N
5	Did the committee follow the agenda?	—
6	Did the committee address most of the items on the agenda?	—
7	Was the communication flow multidirectional (i.e. interaction between members)?	N
8	Did members take notes?	Y
9		
10		

Information Materials Distributed:	Housekeeping Details (next mtg time, place)
No agenda	The next meeting is scheduled for April 10, 1996 at 9:30 a.m. - DCPHU.
No minutes from previous meeting	

MEETING NOTES 4/2/96

Dr. V opened up the staff meeting by complimenting and thanking all of the staff for their participation during the CDC site visit.

Dr. V announced that the CDC site visit was a success.

Dr. V mentioned that the grant manager/evaluation consultant had left the teen pregnancy project. He noted that she realized that she was not the one for the job as grant manager. Likewise, he stated that she left graciously.

Dr. V noted that he would try to replace and find a new grant manager and a evaluator consultant as soon as possible. He stated that he had two people in mind.

Dr. V stated that he wanted to change the structure of the teen pregnancy project. There would be two separate pieces. One piece is the Alliance headed by Annette; the other component is the evaluation piece runned by Dr. W. The two components are to interface as needed (e.g., since reminded)

Dr V mentioned that Rebecca would support Annette and Dr W when needed.

Dr V announced that the ethnographic portion would fall under the Program Evaluation Component. He stated that the new grant manager will have only an administrative role to

MEETING NOTES 4/24/96

ensure the budget was in place.
Until a grant manager was hired, Dr. V stated that all purchase order requests must be approved by him.
Dr. V asked if any one had any comments or questions.
Dr W mentioned that he needed a full-time data input person to work with him. He stated that this person will need to input large portions of data. The person needed to be familiar with data management software packages.
Dr. Y asked Dr. V under which portion the community needs assessment would fall under (e.g., Alliance or Evaluation)?
Dr. V responded by saying whoever we think will be capable to fulfill that commitment.
Rebecca indicated that there was a strong possibility that she would be able to assist Dr W when she completed the tasks for Dr Y by the end of next week.
Rebecca stated that she has and still would like to work with Annette on the Alliance tasks.
I asked Dr V about the future location of the teen pregnancy project.
Dr. V stated the decision to move the project was not finalized.

POST MEETING NOTES*	MEETING NOTES 4/2/96
1. How was the meeting time divided between updates and discussion?	The meeting was spent primarily on discussion.
2. What were the main issues addressed in the meeting?	Results of the CDC site visit, Two components on the teen pregnancy project, Comments and questions
3. What decisions were made?	Two major components of the teen pregnancy project
4. How were the decisions made? How much input did the chairs/facilitators have in decisions?	The director of the health department (DCPHU) announced what he had decided.
5. Was there any disagreement? How was it resolved?	No
6. How was participation distributed across the group?	Everyone (except Domenico) participated although Dr. V participated the most
7. Who did not participate much? Any ideas why?	Domenico as secretary took notes at the meeting.
8. In working sessions, who talked to whom? Any obvious groupings/factions/alliances?	N/A
9. What was the general climate like (relaxed, friendly, formal, rigid, angry, bored)?	formal and a little tense given the grant manager/evaluation consultant recent departure from the project
10. What role did the project coordinator play in the meeting?	Anne the did not play any particular role; she did not facilitate this meeting.
11. What role did the chair/facilitator play in the meeting?	N/A - The director of the health department (DCPHU) facilitated the meeting
12. What role did the evaluators play in the meeting?	The evaluator did not play any particular role in this meeting.
13. Who came in late or left early? Why?	N/A

APPENDIX C
SECTOR COMMITTEE PROFILE

Government/Law Committee

Formation and Purpose:

The Government/Law committee was formed on January 30, 1996 at the first official general meeting of the Jacksonville Alliance for the Prevention of Adolescent Pregnancy (Alliance). At the end of this meeting, individuals and representatives from various organizations were encouraged by the project coordinator, Annette Jones[1] and the interim grant manager, Sheila Ryan to sign up and join the Government/Law committee.

Representatives from two organizations and one individual signed up to participate in the Government/Law committee. The organizations included:

- State Attorney's Office
- Emergency Pregnancy Services

All attendees at the general meeting received information regarding the date, time, and location of the first meeting for the Government/Law committee. Everyone received a handout describing the purpose and areas for consideration by this committee. Also a handout was distributed outlining the tasks of the committee.

The purpose of this committee was to work with law enforcement, legal and legislative leaders to promote the enhancement of health education and adolescent pregnancy prevention programs, and support consistent enforcement of criminal laws in the community affect teens

Areas for consideration by the committee:

- Enforce legislation/laws and encourage community-based specialized projects related to opportunities necessary to expand life options to all teens in the community

- Work to strengthen laws that prohibit adults from having sex with minors and educate the community more fully on the issue

The project coordinator assigned committee tasks prior to the first meeting. The committee was asked to complete the following tasks:

1. Identify needs specific to adolescents within committee area

2. Identify barriers within committee areas that hinder providing information to teens and delivering needed services to teens

3. Identify tasks which may be accomplished within committee area to assist teens

[1] All names have been changed to protect the identities of the participants.

and to prevent pregnancy

4. Increase awareness of the need for teen pregnancy prevention and incorporate leaders in the committee area in developing intervention strategies

Meeting Summaries

March 5, 1996

I. Membership Participation and Information Materials

Members Present	Staff Present
Vivianne Kelly	Domenico Herrerra
Lisa Robinson	Annette Jones
Melissa Brown	Nicole Allen

The first meeting of the Government/Law committee met at the Duval County Public Health Unit in conference room A. Annette Jones convened the meeting at 4:00 p.m. Members received an information packet that included the following items:

- an agenda
- a committee roster
- a handout listing the purpose of the nine committees of the Jacksonville Alliance
- a handout listing the purpose and suggested areas of consideration for the Government/Law committee
- a handout listing committee tasks
- a handout listing committee goals and timeline
- a handout listing committee chair/facilitator responsibilities
- literature about adolescent pregnancy

The literature in the packet included the following:

1. "Why Do Teens Become Pregnant" by Loraine Gaston, New Futures School, Albuquerque, NM
2. "What Must Be Done To Prevent Teen Pregnancy," Author Not Indicated
3. "Adolescent Pregnancy: A Summary of Prevention Strategies," by The Center for Population Options
4. "Adolescent Sexual Behavior, Pregnancy and Parenthood," by Advocates For Youth
5. "Adolescents Are Not Just Short Adults," by Marion Howard, Ph.D.
6. "Adolescent Pregnancy Prevention: Effective Strategies," by National Adolescent Health Information Center, University of California, San Francisco
7. "Do We Need To Promote Responsible Sexual Decision Making In Adolescents? Look At The Facts," Compiled by the First Coast Adolescent Health Consortium

8. "Criminal, Family, And Other Support Laws Relating To Teenage Pregnancy" by Charlene Carres in Impact of Teenage Pregnancy in Florida: Issues, Implications and Recommendations for Prevention and Intervention.

II. Introductions and Alliance Overview

Those present introduced themselves. Annette Jones, project coordinator reviewed the purpose of the Jacksonville Alliance and the committee structure. Members were told that the Jacksonville Alliance is one component of a grant received by the Duval County Public Health Unit from the Centers for Disease Control (CDC). The project coordinator explained that the grant is a two-year project that will address the problem of adolescent pregnancy and work towards the development of effective prevention strategies. Furthermore, members were told that The Jacksonville Alliance would develop a Community Action Plan (CAP) by September 1997 that will be presented to the CDC. At that time, the Jacksonville Alliance will have the opportunity to apply for a continuation grant that is up to five years of implementation funding.

The project coordinator emphasized that the committee structure of the Jacksonville Alliance is designed to mobilize all segments of the community to address the problem of teenage pregnancy. Members were told that the Government/Law committee would address issues regarding teenage pregnancy prevention that are specific to governmental agencies in our community.

III. Committee Tasks and Goals

Annette guided members through the information packet. She discussed in detail the timeline for accomplishing committee tasks and goals. By February 1997, the committee will have selected three projects to pilot and/or implement in the Jacksonville community. Likewise, the chair of the committee will provide three reports that will be used to inform the CDC of the committee's progress. In addition, the final report will contain specific suggestions for the CAP that will be compiled by the staff of the Jacksonville Alliance. Members were told that the staff of the Jacksonville Alliance would be available to assist committee members in accomplishing their goals.

IV. Meeting Activity: Committee Discussion

Committee members discussed their experiences with teenage pregnancy issues. Lisa Robinson stated that she works at Emergency Pregnancy Services, a non-profit organization that assists women who are pregnant and in crisis. The women must meet financial eligibility requirements and are referred through various other organizations. Vivianne Kelly stated that she was a former schoolteacher who now works in the Juvenile Department in the State Attorney's Office. Melissa Brown stated that she also works at the State Attorney's Office. Issues brought up by the committee included older males impregnating teens and statutory rape laws.

Nicole Allen described her work with the Alliance. Nicole stated that she is working with Dr. Y, anthropologist on the Alliance staff, to create an ethnography that will provide a qualitative report on the status of Jacksonville's teens. Currently, Nicole is conducting focus groups with teens at various religious organizations. Interviews will also be completed at a later date. Vivianne expressed concern about biased sampling methods.

Annette suggested that press releases mention the support of governmental agencies like the State Attorney's Office and HRS. Annette also pointed out that it might be beneficial to some committees' efforts to have joint committee meetings and to work more closely with one another. Committee members were asked to be prepared to discuss strengths and barriers facing the government/law sector of our community in addressing teenage pregnancy.

Annette announced that Terry Thompkins would join this committee. Terry is involved at the State legislative level and will bring her knowledge to this committee. Committee members were asked to recruit other community members to join the Alliance and/or this committee. Vivianne recommended that in order to increase committee attendance, that the next committee meeting be held at the courthouse.

V. Housekeeping Details

At the time of this meeting, no committee chairperson had been chosen; however, Melissa Brown volunteered to chair the Government/Law committee. The next meeting of the Government/Law committee was scheduled for Thursday, April 18, 1996 at 4:00 p.m. at the Duval County Courthouse, Room 054. Annette adjourned the meeting at 5:00 p.m.

April 18, 1996

I. Membership Participation and Information Materials

Members Present		Staff Present
Cassandra Allman	Lisa Robinson	Rebecca Woods
Trina Schneider	Melissa Brown, chair	Annette Jones
Vivianne Kelly		Nicole Allen

The second meeting of the Government/Law committee was held at the Duval County Courthouse, room 504. Melissa Brown convened the meeting at 4:00 p.m. Members received an information packet that included the following items:

- an agenda
- a committee roster
- a committee packet overview

- literature about adolescent prevention strategies, prevention programs and assessments, adolescent sexuality research, and school based health centers

The literature in the packet included the following:

1. "Preventing Teenage Pregnancy: Some Questions to Be Answered and Some Answers to Be Questioned" by Marion Howard, Ph.D. and Marie Mitchell, R.N.
2. "Adolescent Pregnancy Prevention Programs" by American College of Obstetricians and Gynecologists Committee on Adolescent Health Care
3. "The Effects of Contraceptive Education on Method Use at First Intercourse" by Jane Mauldon and Kristin Luker
4. "The Determinants of First Sex by Age 14 in a High Risk Adolescent Population" by Frank Mott, et al.

II. Introduction and Review of Old Business

Those present introduced themselves. Rebecca Schulz began the meeting by asking committee members if they had any comments or questions regarding the minutes from the last Government/Law committee meeting. Lisa Robinson indicated that her organization, Emergency Pregnancy Services (EPS), had no financial eligibility requirements. The past minutes erroneously stated that EPS clients must meet eligibility requirements. The error was noted and the minutes were amended and approved. Annette Jones informed the committee that all committee meetings will be taped and an audio archive of committee meetings will be created.

Annette reviewed that the committee structure of the Alliance is designed to mobilize all segments of the community to address the problem of teenage pregnancy. Many committees have identified strengths and barriers within the Jacksonville community. Annette stated that this information, along with information collected by the Alliance will help the committee design interventions and other projects that will be tailored to address the teenage pregnancy is Terry as it exist in Jacksonville. Likewise, the Government/Law committee will address issues and solutions regarding teenage pregnancy prevention that are specific to the Government/Law community.

III. Committee Tasks and Goals

The agenda for the meeting indicated that members were to address the following items: a) review committee meeting minutes, b) review strengths in the community for prevention efforts, c) committee feedback on research and education materials, d) discuss new committee members, and e) new business - CDC site visit, - legislative update.

IV. Meeting Activity

The committee engaged in a discussion of strengths in the Government/Law community in Jacksonville relating to adolescent pregnancy prevention. The committee also

discussed barriers and possible intervention projects. The results of this discussion were as follows:

Strengths

- Prosecution of sex offender with the lewd and lascivious offense
- School programs
- HRS Family Response Team - holistic approach in addressing abuse/neglect
- Religious community and religious youth programs
- Youth service organizations which foster citizenship
- Full service school initiative
- STD clinic and outreach van

Barriers

- Parents, agencies, and educators all need a better understanding of laws relating to sex crimes
- Reporting issues-balancing trust of client with desire to report sex crime to the authorities
- Having to report to the Sheriff's Office because HRS will not accept calls at the "800" number
- Interviewing by Sheriff's office may interfere with giving history/information
- Problem with older males impregnating younger females
- Lack of truancy enforcement and lack of curfew laws
- Cultural norms give mixed messages about what is acceptable behavior

Interventions

- Utilize student and community groups, STD clinics to disseminate information
- Increase awareness of prosecution of specific statues
- Increase awareness of physicians of child abuse and statutory rape issues
- Use of victim advocates for interviewing in consensual lewd cases (vs. police)
- Increase awareness of educators to legal issues
- Increase awareness of youth to what types of behavior are against the law
- Bar outreach about minors and consensual lewd and lascivious offenses
- Interventions with high risk youth in juvenile justice system
- First time offender programs
- Addressing cultural myth of relationships with older men

The committee briefly discussed the approval of the new Health/Sexuality curriculum in the Duval County Public Schools. Annette said that she would bring that curriculum to the next Government/Law committee meeting.

Annette reminded the committee that it might be beneficial to have joint committee meetings and to collaborate in activities with other committees. She commented that

many committees are naming similar strengths and barriers. Likewise, Annette stated that committee chairs would be meeting to discuss the objectives of the Alliance.

V. Housekeeping Details

Annette informed the group that information packets would now be distributed with a summary page categorizing the articles for easier filing. She also informed the committee that the next meeting would be used to discuss future objectives and specific projects of the committee. Annette updated the committee on the successful CDC site visit of the Jacksonville Alliance.

The next meeting of the Government/Law committee was scheduled for Wednesday, May 29, 1996 at 4:00 p.m. at the Duval County Courthouse, room 504. Members were strongly encouraged to attend since it would be a critical meeting in the planning of future committee activities. Melissa adjourned the meeting at 5:00 p.m.

May 29, 1996

I. Membership Participation and Information Materials

Members Present	Staff Present
Melissa Brown, chair	Rebecca Woods
Trina Schneider	Annette Jones
Lisa Robinson	

The third meeting of the Government/Law committee was held at the Duval County Courthouse, room 504. Melissa Brown convened the meeting at 4:05 p.m. Members received an information packet that included the following items:

- an agenda

II. Introduction and Review of Old Business

Melissa thanked those present for committing their time to the Jacksonville Alliance. Annette Jones reviewed the process completed by the committee so far. Strengths and barriers within the government/law community have been identified by committee members as well as general issues facing teens associated with pregnancy prevention.

III. Committee Tasks and Goals

The agenda for the meeting indicated that members were to address the following items: a) review overall strengths and barriers, b) objective planning process, c) developing objectives for committee, d) discussion of research material and literature: 1) requests for

additional topic areas, 2) Needs assessment data, 3) Y's 5/1/96 Presentation, and e) staff update: 1) CDC Technical Assistance Workshop, 2) Semi-Annual Report.

IV. Meeting Activity

Annette highlighted some important points from Dr. Y's talk at the May 1st Alliance meeting. The group discussed the teen births rates among the 10-14 and 15-17 year old age groups are remaining stable while the teen birth rates among 18-19 year olds are falling. The committee will decide if all teens or if only unmarried teens should be the focus of their efforts, and with which age groups. Consideration should also be given to the nature of relationships teens have. The committee members stressed that teens need to be involved in the decision-making process, in this committee as well as all other committees of the Alliance.

The group decided that this meeting would begin the process of developing goals and objectives for the committee to complete in the Jacksonville community to address the issue of adolescent pregnancy prevention. Annette guided committee members through information packets distributed at the meeting. Sections from the United Way/JCCI "Getting Results and Knowing It" are included to guide the objective planning of the committee. Also, the Duval County School Board Comprehensive Health Education Program Parent Handbook was included for committee members' review, along with additional Life Options research.

The committee reviewed the overall vision and mission statements for the Alliance and engaged in a discussion to determine goals of the committee. Members decided that objectives would be developed at the next meeting, after which the committee can begin to implement its specific projects to address adolescent pregnancy prevention. Other issues discussed by the committee included the following:

- Highlighting the importance of victim advocacy in the interviewing process in cases regarding sexual offenses
- Developing outreach programs based on the new movement of child care in casinos
- Increasing committee membership to include teens, Jacksonville Sheriff's Office, HRS and other representatives
- Stressing the importance of involving teens in Alliance efforts and possibly using teens as volunteers in intervention efforts
- Barriers facing pregnant and parenting teens in receiving services, policy issues, consistency in services, and changes after public health and HRS separate
- Increasing the awareness of the exploitation associated with adult male/teen female relationships

Based on the past work of the committee, research, local needs assessment information, and the issues discussed above, the committee decided on the following goals:

- To establish mandatory minimum penalties for adults convicted of lewd and lascivious acts with a minor and adults convicted of sexual intercourse with a minor

- To reduce the acceptability of sexual relationships with minors through community education

Annette asked the committee to review the objective planning information from "Getting Results and Knowing It" for the next committee meeting and begin preliminary objective outlines on committee worksheets.

Lisa Robinson presented a catalogue of teen pregnancy prevention efforts across and offered to recruit some of the teens at Emergency Pregnancy Services for this committee. Melissa Brown said she would bring a copy of the sex offense statutes to the next committee meeting.

V. Housekeeping Details

The next meeting of the Government/Law committee of the Jacksonville Alliance was scheduled for Tuesday, July 2, 1996 at 4:00 p.m. at the Duval County Courthouse, room 504. Melissa adjourned the meeting at 5:15 p.m.

July 2, 1996

I. Membership Participation and Information Materials

Members Present	Staff Present
Melissa Brown, chair	Rebecca Woods
Lisa Robinson	Carl Walton III
	Annette Jones
	Nicole Allen

The fourth meeting of the Government/Law committee was held at the Duval County Courthouse, room 504. Melissa Brown convened the meeting at 4:15 p.m. Members received an information packet that included the following items:

- an agenda

II. Introduction and Review of Old Business

Annette Jones introduced Carl Walton III, the new Grant Manager and Evaluation Consultant for the Alliance.

III. Committee Tasks and Goals

The agenda for the meeting indicated that members were to address the following items: a) review committee goals, b) objective planning for goals, c) timeline for projects, d) committee membership, and e) new business.

IV. Meeting Activity

Lisa Robinson told the group that she has been collecting newspaper clippings relating to teenage pregnancy. Annette requested that Lisa share this information with the Government/Law committee and possibly with the Alliance. It would be valuable to see what kinds of media coverage are given to teen pregnancy issues and how it may affect Alliance efforts at prevention.

The group discussed the need to increase membership in this committee to ensure adequate representation from all segments of the government/law community. Some possible sources for recruitment include HRS, the Jacksonville Sheriff's Office, the Department of Juvenile Justice, the Attorney's General's Office, the City's Victim Services Division, and the community. Lisa will personally invite Eva Copeland, a community member interested in the Alliance, to the next Government/Law committee meeting. Other people to be contacted are Steve Ward at HRS, the sex crimes unit of the JSO, Wanda Walker at St. Vincent's, and Wanda Holley at Victim Services.

The group reviewed the goals named at the previous committee meeting. The intent of this meeting was to choose objectives to achieve the goals. The goals are listed below:

Goal 1: To establish mandatory minimum penalties for adults convicted of lewd and lascivious acts with a minor and adults convicted of sexual intercourse with a minor.

Goal 2: To reduce the acceptability of sexual relationships with minors through community education.

The committee began a discussion to develop objectives to achieve the goals listed above. The committee addressed the following issues:

- The committee discussed current legislation that addresses adults engaging in sexual acts with minors. Copies of legislation could possibly be obtained from Terry Thompkins or Judy Linder. Alliance staff will contact Terry Thompkins to see if she has any current information.

- Melissa told the group of an initiative by the Department of Juvenile Justice which consisted of the distribution of a letter to all high school students, informing them of the prosecution of juveniles as adults. This could be a model for the committee to distribute information for Goal 2 to inform teens that it is illegal to have intercourse with an adult. This could be a collaborative effort with the Education committee.

- Lisa told the group that St. Vincent's has a media department that could possibly be a resource for the Alliance's media efforts.

The group discussed the following action steps/objectives related to Goal 1 that are to be accomplished by fall 1996.

- The committee will hold a meeting with state legislators who might support the desired legislation for Goal 1.

- The committee must first develop a document containing supporting information to justify the request for mandatory minimum penalties. The following steps are needed to create this document.

    1. Gather supporting statistics on economic impact, social impact, and number of teen births.

    2. Provide an overview of the teen pregnancy problem and why they should be interested.

    3. Examine welfare changes and their effects on teen pregnancy.

The committee decided to make contacts with the following state legislators to attend the meeting: Fred Troy, Ronald Blue, and Christopher Banks. The Attorney General will also be invited. The following issues will be discussed with the legislators:

1. What process should be used? (Create new legislation or amend current legislation)
2. Are they interested in increasing penalties for these crimes?
3. What kind of funding is available to support this effort?
4. Do we have their support and how can we get support from other parts of the State of Florida?

- The committee will contact other organizations, local and statewide, to assist in their efforts. Some possible organizations are JCCI, Respect Life, True Love Waits, National Association of Social Workers, JSO, School Board, Heath Department, and others.

- Logistical issues will also have to be addressed, such as planning the date and mailing invitations, etc.

The next meeting will be used to accomplish the above objectives and to name objectives for Goal 2. For the next meeting, members agreed to recruit new members for the committee. Melissa agreed to contact the Attorney General's Office, and Lisa agreed to contact Terry Thompkins and Rebecca Rankin to see if JCCI can assist in our efforts.

V. Housekeeping Details

The next meeting of the Government/Law committee of the Jacksonville Alliance was scheduled for Wednesday, August 7, 1996 at 4:00 p.m. at the Duval County Courthouse, room 504. Melissa adjourned the meeting at 5:20 p.m.

August 7, 1996

I. Membership Participation and Information Materials

Members Present	Staff Present
Melissa Brown, chair	Annette Jones
Terry Thompkins	Nicole Allen
Trina Schneider	
Vivianne Kelly	
Lisa Robinson	

The fifth meeting of the Government/Law committee was held at the Duval Courthouse, room 504. Melissa Brown convened the meeting at 4:10 p.m. Members received an information packet that included the following items:

- an agenda
- minutes
- JCCI Steering Committee Teenage Single Parents and Their Families Update on 1996 Legislation 6/17/96
- Florida Times Union 8/5/96 article on teenage pregnancy entitled "New law designed to protect girls from adult males"

II. Introduction and Review of Old Business

Members made no changes to previous meeting minutes or to the agenda.

III. Committee Tasks and Goals

The agenda for the meeting indicated that members were to address the following items: a) review and discuss committee goals and objectives, b) guest speakers, c) event preparation and planning, d) project timeline, and e) new business.

IV. Meeting Activity

Committee members were asked to give reports on their information gathering tasks assigned at the previous meeting concerning **Goal 1**: To establish mandatory minimum penalties for adults convicted of lewd and lascivious acts with a minor and adults convicted of sexual intercourse with a minor.

Melissa reported that she spoke with the Attorney General's Office about the committee's goals. Though supportive, they were cautious of the group's desire to create new legislation requiring mandatory minimums for adult sexual offenses involving contact with a minor. Melissa commented that prison overcrowding would be a priority that the committee would need to address up front with legislators. Melissa stated that there is currently a law with felony penalties for adults who have sex with children under 16. She

stressed to the group that the problem is not the law, but rather getting the cases into the system.

Lisa Robinson reported on her meeting with state legislator, Fred Troy. She summarized some of his concerns, which were similar to those of the Attorney General Office. He suggested that committee members get support from as many Sate Attorneys in Florida as possible for any new legislation. He also suggested that the committee meet with other legislators such as Christopher Banks and Steve Wise, and gain their support. Fred Troy has agreed to reserve one of his six legislative "spots" (used for introducing bills during the session) for whatever legislation the committee composes for this issue. He offered his staff's assistance to the committee for creating the language for the legislation. Lisa has contacted Christopher Banks's office and reserved some times for next week for a meeting. She would like some other members to accompany her.

Terry Thompkins reported on the legislative recommendations of two 1995 teen pregnancy studies (from the Education Employment Council for Women and Girls and JCCI), and developments of last year's legislative session (see JCCI Steering Committee Teenage Single Parents and Their Families handout). Both studies recommended strong action regarding adult males sexually involved with teen girls, and the need for legislation that did not involve proving chaste character of the female (current statutory rape law). She stated that legislative change was possible last year due to many reasons. The EEC study received local, regional and national press. The Women's Caucus and other groups met regularly with state legislators and influential groups (e.g., State Attorneys). The newly passed legislation holds penalties for adults who impregnate minors (see C. Banks editorial). She suggested the committee amend its goals to follow existing legislation and the new laws to see if they will work before looking to add more legislation. She stated that the new laws go into effect in October.

Members discussed the ineffectiveness of the 800 Abuse Hotline. Likewise, members discussed that it is difficult to show the impact of teen pregnancy in Florida, since the State of Florida does not collect abortion data. Terry stated that the committee may want to consider working on getting a law passed that would require the State of Florida to accumulate data on abortion. Without abortion data, it is difficult to know the extent of the problem of teen pregnancy. Furthermore, teen pregnancy is not just a black problem, and there is a need to educate people on this issue.

Committee members began to discuss options for consideration given the feedback from Melissa, Lisa and Sue's reports. The group discussed continuity issues of the legislation passed last year. Members discovered that the new legislation actually holds a lesser penalty (3rd degree felony) for impregnating a child under 16 years old than the existing law for lewd and lascivious (2nd degree felony). Members discussed these laws and two additional sex offense laws for adults having sex with minors. The group identified the need to clarify new and existing laws … for legislators, child abuse workers, teachers, social workers, and teens.

Vivianne and Melissa agreed to pull the new legislation, and compile new and existing statutes in a format where they can be compared for continuity of content and penalties.

Lisa and Trina said they would meet with Senator Bankhead either on August 14th or 15th to inform him on the progress of the Jacksonville Alliance and this committee, and gather his feedback.

Annette recommended that the committee come up with a workshop for teachers, nurses, etc. to introduce them to the new legislation.

The group discussed the following revised objectives for Goal 1:

- Encourage legislators to amend current legislation to represent a continuity of content and penalties for having sexual content or impregnating a minor.

- The committee will initiate a project to determine how State Attorney's are utilizing the laws.

- The committee will develop educational materials (and perhaps workshops) that will familiarize professionals (teachers, etc.) and parents with the new legislation, and encourage their reporting of adult/minor relationship to authorities.

- The committee will develop and distribute educational materials and develop programs targeted at teens to discourage relationships with adults. The group discussed creating PSAs modeled after drunk driving and other campaigns for youth (i.e. If you do this, you'll be treated like an adult by the courts). The committee members agreed to fully discuss these objectives at the next meeting.

V. Housekeeping Details

The next meeting for the Government/Law committee is scheduled for Tuesday, August 27, 1996 at 4:00 p.m. at the State Attorney's Office, room 504 at the Duval County Courthouse. The meeting was adjourned at 5:10 p.m.

August 27, 1996

I. Membership Participation and Information Materials

Members Present	Staff Present
Melissa Brown, chair	Annette Jones
Eva Copeland	
Trina Schneider	
Vivianne Kelly	
Lisa Robinson	

The sixth meeting of the Government/Law committee was held at the Duval County Courthouse in room 504. Melissa Brown convened the meeting at 4:10 p.m. Members received an information packet that included the following items:

- an agenda
- minutes
- Christopher Banks Meeting Summary
- handout on new and existing laws regarding adult sexual contact with minors

II. Introduction and Review of Old Business

Melissa requested an order change on the meeting's agenda; reversing items II and III. Lisa Robinson commented that the minutes from the previous meeting incorrectly stated that Christopher Banks, not Fred Troy, had reserved one of his six-bill introduction "spots" for the Jacksonville Alliance. The minutes were approved given this correction.

III. Committee Tasks and Goals

The agenda for the meeting indicated that members were to address the following items: a) review and discuss legislation, b) Christopher Banks meeting summary, c) outreach planning: target groups, contacts, timeline, d) preparation for September 25th Alliance meeting, and e) new business.

IV. Meeting Activity

Lisa summarized her August 14th meeting with Senator Christopher Banks. They discussed the mission and vision of the Jacksonville Alliance, as well as the overall goals of the Government/Law committee. Senator Bankhead contacted Brad Thomas, Chairman of the Criminal Justice Committee to discuss clarification of SB 200 and other related legislation. Both Mr. Carland Senator Bankhead provided Lisa with valuable feedback for the Jacksonville Alliance. Their overall recommendations were as follows:

- Involve local and statewide state attorneys to gain their support in prosecuting crimes utilizing the new laws and requesting sentencing via the guidelines. State attorneys are also key in encouraging the community to report the crimes prosecuted by the new laws.

- The reporting process should be clarified within the community. The committee should identify the reporting agencies and clearly define and promote the process.

- The committee should develop a public awareness campaign that educates the community about the new laws and encourages reporting to the appropriate authorities.

Melissa updated committee members on the new and existing laws regarding adult sexual contact with minors. Melissa had each law enlarged to poster size so that the committee could review key points simultaneously. She pointed out similarities and differences between the existing and new laws, and how they may be used together. She summarized:

- The existing lewd and lascivious law (F.S. 800.04) is a 2nd degree felony for 18+-year-old offenders with <16-year-old victims.

- New law (CS/SB 200) allows state attorneys to charge offenders with both this 3rd degree felony child abuse charge, as well as F.S. 800.04. The defendant must be 21+ years old and impregnate a female <16 years old.

- New law (CS/HBs 543 & 1317) makes it unlawful for adults 24+ years old to have sexual contact with a minor under 18 years old. Conviction under this law results in a 2nd degree felony. Prior sexual conduct of the victim is irrelevant.

Melissa stressed to the committee that any shortcomings of the laws are not the real problem … but rather the lack of reported crimes. From this discussion, the group decided that they would revise the committee goals to accommodate community education efforts to increase awareness and encourage reporting based on the new laws. It was also decided that the committee would NOT pursue proposing additional legislation at this time.

Members discussed the following action items for the upcoming meetings:

- Trina will make contacts with HRS District IV administration to gather information on any policy currently in place to report adult-minor relationships identified by abuse investigators, economic services, etc.

- Trina also suggested contacting the Children's committee of the Health and Human Services Board to schedule a presentation by the Government and Law committee about the new laws, the role of adult-minor relationships and adolescent pregnancy, and encouraging increased reporting by service providers.

- Lisa encouraged the committee to focus on agencies and professionals who may be reluctant to report adult-minor relationships due to the exception clause in the legislation.

- Melissa will ask a representative from the JSO to address the committee and discuss the logistics of handling an influx of reports under these new laws.

- The committee will work on the development of educational materials (and perhaps workshops) that will familiarize professionals (teachers, etc.) and parents with the new legislation, and encourage their reporting of adult/minor relationships to authorities.

- The committee will also plan the development and distribution of educational materials and develop programs targeted at teens to discourage relationships with adults. The group discussed creating PSAs modeled after drunk driving and other campaigns for youth (i.e. If you do this, you'll be treated like an adult by the courts).

V. Housekeeping Details

The next meeting for the Government/Law committee is scheduled for September 11, 1996 at 4:00 p.m. at the State Attorney's Office, room 504 at the Duval County Courthouse. The meeting was adjourned at 5:00 p.m.

September 11, 1996

I. Membership Participation and Information Materials

Members Present	Staff Present
Melissa Brown, chair	Annette Jones
Eva Zick	Nicole Allen
Lisa Robinson	

The seventh meeting of the Government/Law committee was held at the Duval County Courthouse, in the State Attorney's Office Kids Room. Melissa Brown convened the meeting at 4:30 p.m. Members received an information packet which included the following items:

- an agenda
- newspaper article from The New Mexican 9/1/96 entitled "Agency helps pregnant minors wed adult dads"
- newspaper article from The Florida Times Union 9/1/96 entitled "Tough sentencing guidelines ignored"
- legislation regarding new laws from Senate Committee on Criminal Justice

II. Introduction and Review of Old Business

Due to scheduling conflicts with depositions at the State Attorney's Office, the committee held a brief meeting.

III. Committee Tasks and Goals

The agenda for the meeting indicated that members were to address the following items: a) approval of minutes, b) finalize September 25th Alliance meeting presentation, c) HRS District IV update, c) JSO update, d) HHB update, e) other target groups, f) educational materials: design, content, cost, etc., and g) new business.

IV. Meeting Activity

Members quickly reviewed the upcoming Alliance meeting on September 25th, and the presentation by the Government/Law committee. Melissa agreed to send copies of the legislation that she will present on September 25th to the Alliance staff to make overheads.

Lisa shared a news article from a paper in California with some shocking views on adult/minor relationships and pregnancy. Members discussed some of the implications of this article of forcing adult men to marry teens who they impregnate (e.g. child abuse). Melissa added to the discussion by talking about her current deposition with pedophiles. Annette shared a recent FTU article on enforcement of sentencing guidelines in Florida.

Members agreed to discuss the HRS District IV update (Lenora), JSO update (Melissa) and education outreach planning at the next meeting.

V. Housekeeping Details

The next meeting of the Government/Law committee was scheduled for Wednesday, October 16, 1996 at 4:00 p.m. at the State Attorney's Office, room 504.

APPENDIX D
TYPES OF DATA COLLECTED

Types of Data Collected During Fieldwork

Program Documents:

- Department of Health and Human Services Centers for Disease Control and Prevention Program Announcement 547 Community Coalition Partnership Programs for the Prevention of Teen Pregnancy (received by DCPHU on 7/14/95)
- Community Coalition Partnership Programs For The Prevention Of Teen Pregnancy grant application submitted by DCPHU circa 8/95
- Department of Health and Human Services Centers for Disease Control and Prevention Program Announcement Number 760 Community Coalition Partnership Programs for the Prevention of Teen Pregnancy Phase II
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy Community Coalition Partnership Programs for the Prevention of Teen Pregnancy – Phase II grant application submitted by DCPHU
- 1996 Planner
- First Coast Adolescent Health Consortium Bylaws
- Flow chart of pre-coalition activities and initial formation of Jacksonville Alliance
- Handouts on purpose of committees, committee goals, committee tasks, and committee chair/facilitator responsibilities distributed at first coalition meetings and committee meetings
- General community coalition meeting minutes and field notes from January 1996 – March 1998 (7 out of 8 scheduled meetings)
- Executive committee meeting minutes and field notes from May 22, 1996 – March 9,1998 (19 meetings, March 9, 1998 first meeting of Board)
- Documentation for general coalition meetings, meetings of committees regarding formation, purpose, membership participation, information materials, introduction, review of old business, committee tasks and goals per meeting, meeting activity, and housekeeping details during the first year of the coalition – Phase I

- Jacksonville Alliance membership lists (10 lists from January 1996 through April 1998)
- Staff meeting minutes and field notes from January 3, 1996 to March 12, 1998 (84 out 88 scheduled meetings)
- Five guidelines for semi-annual reports (4/30/96, 10/30/96, 4/30/97, 12/15/97, 4/30/98)
- Five semi-annual reports (4/30/96, 10/30/96, 4/30/97, 12/15/97, 4/30/98)
- Map of Jacksonville, Florida – Duval County indicating names of communities
- Demographic profile of 32205 zip code compiled by DCPHU – September 1995
- Demographic profile of 32206 zip code compiled by DCPHI – September 1995
- Demographic profile of 32208 zip code compiled by DCPHU – September 1995
- Demographic profile of 32209 zip code compiled by DCPHU – September 1995
- Ethnographic Study Design of Adolescents in Jacksonville
- Ethnographic Study Abstract
- List of questions for open-ended interviews and focus groups with teens
- Ethnographic report: "Growing Up in Duval County An Investigation of Social Arenas, Peer Groups, and Romance Among Jacksonville's Teen Population" July 1996
- Public Health Services HRS Duval County Public Health Unit
- History and Organization of HRS (abbreviated)
- Department of Administration –OPS (handout)
- Meeting Satisfaction Survey (6/96)
- Duval County Schools & Sexuality Education Historical Perspective handout
- Jacksonville Alliance ballot form to add Pregnant and Parenting Teens committee
- Memo on funding request for additional staff for Jacksonville Alliance
- Jacksonville Alliance In Kind Donations Report 4/1/96 – 9/30/96
- Volunteer Time and In-Kind Donation Form

- Jacksonville Alliance Logistical Information for the Coordinator (10/21/96)
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy Brochure
- Media/Promotional Packet: Vision and Mission Statement, Committees' Purposes, Adolescent Pregnancy Prevention Overview, and the Center for Population Options Adolescent Pregnancy: A Summary of Prevention Strategies,
- Teen Pregnancy Prevention and Intervention Mentoring and Teen Health Advisors Training Program (session schedules)
- HRS Vicinity Mileage Trip Logs (2/16/98 – 3/1/98)
- 1997 Planner
- DRAFT Guidance and Benchmarks for the Community Action Plan 2/16/97
- Guidance for the Community Action Plan March 6, 1997
- Questionnaire form for resource directory
- Adolescent Pregnancy Prevention Services Directory March 1997
- Cover letter dated 4/10/97 requesting funding for Teen Issues Conference with conference itinerary
- Bylaws For The Jacksonville Alliance For The Prevention Of Adolescent Pregnancy DRAFT April 1997
- Jacksonville Alliance Teen Pregnancy Reduction Grant Meetings March – April 1997 (3 meetings)
- Jacksonville Alliance Adolescent Family Life Demonstration Grant Meeting- April 1997
- Implementation plans of needs and assets assessment
- Needs and assets assessments (Jacksonville)
- Needs assessment instruments (e.g. Teen Behavior & Opinion Survey)
- Community leaders group telephone interviews (3)
- Community Leaders Meetings Zip code 32206, 32208, 32209 (3 meetings)
- Community Leaders Membership Roster May 1997
- Memo on workshop by Dr. LaFrancis Rogers-Rose

- Potential questions to be examined (at workshop by Dr. Rogers- Rose)
- Sample Letter for support and agreement of Community Action Plan
- 45 Needs Identified By Community Forums, Key Informants, Focus Group, and Local Surveys
- Five "Core" Needs handout
- Working model time line of Jacksonville Alliance work groups
- Jacksonville Alliance work groups May – June 1997 (4 meetings)
- Interagency Meeting June 19, 1997 notes and roster
- Goals developed by workgroups based on identified five top need areas
- Submission dates for cross-site indicators 7/9/97
- Scheduled implementation of interventions 7/8/97
- Duval County Public Health Unit Organizational Chart Division Management Team (2/96)
- Duval County Public Health Organizational Chart (10/2/96)
- Table Of Organization For The Adolescent Pregnancy Prevention Program (1997)
- Table Of Organizational Structure Of Jacksonville Alliance (1997)
- Flow chart of program model (draft - one alternative)
- Flow chart of program model (draft – another alternative)
- Flow chart of program model (draft – another alternative)
- Flow chart of program model (submitted with CAP)
- Flow chart of six key aspects of community action plan development and updating process
- Engaging, Mobilizing, And Organizing The Community (Alliance project coordinator's perspective)
- Community Development As Intervention Through Participatory Action Research (PAR) (Alliance project coordinator's perspective)

- Implementation Strategy & Plan: Community Development Intervention (Alliance project coordinator's perspective)
- Alliance project coordinator's categorization of community development and program development
- Cover letter dated 7/2/97 and Draft of Community Action Plan submitted to Executive committee members
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy Community Action Plan July 9, 1997
- Community Action Plan Summary
- Cover letter dated 8/12/97 to general membership about formalizing Alliance membership, CAP feedback, and board development
- Suggestions for Board Development form
- Community Action Plan General Membership Response form
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy Membership Application for August 1997 – October 1998
- Issues to consider in your committee area (handout)
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy Organizational Summary (page)
- Key facts about the Jacksonville Alliance for the Prevention of Adolescent Pregnancy
- Community Organizing "Partnerships" & "Participation" (handout)
- Lessons Learned and Challenges (handout)
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy Fact Sheet
- Cover letter dated 9/10/97 and Coalition Member Survey
- Cover letter dated 10/13/97 and Coalition Member Survey
- Jacksonville Alliance Committee Updates October 1997
- Community Partnership For The Protection Of Children Community Engagement Subcommittee agenda, and handouts (10/14/97)

- Certificate of Appreciation in support of the Faith Community Network Initiative – The Department of Juvenile Justice 10/16/97
- Certificate of Training "Talking About Sex Teaching Parents How to Help Teens" – Planned Parenthood of Northeast Florida, Inc. 10/12/97
- Letter from the Executive Director of Planned Parenthood 10/22/97 –response to coalition member survey
- Employee Connection A Publication of the Duval County Health Department (3 issues from October 1997 – May 1998)
- Jacksonville Alliance Committee Updates October 1997
- Jacksonville Alliance Committee Updates November 1997
- Cover letter dated 11/10/97 and Coalition Member Survey
- Review of local and national parenting programs and other resources for parent with adolescents (handout)
- Project Administration Form Cross-Site Indicators December 1997
- Jacksonville Alliance Committee Updates December 1997
- Community Organization, Management, Mobilization And Support (Alliance coordinator's perspective)
- 1998 Planner
- Jacksonville Alliance for the Prevention of Adolescent Pregnancy 1998: A year in review
- Jacksonville Alliance Committee Updates February 1998
- Teen Pregnancy Prevention Quality Management Board Duval County Health Department Report Of Recommendations February 17, 1998
- Letter of Resignation from Alliance Project Coordinator dated February 26, 1998
- Coalition Member Survey Report March 1998
- Statistical analyses of coalition member surveys (t-tests, descriptive statistics)
- Cover letter dated 1/21/98 to CDC Program Manager regarding request to see my field notes
- Jacksonville Alliance Committee Updates February 1998

- Adolescent Pregnancy Prevention Program (mission, goals, objectives, program services, activities/neighborhood matrix) –
- CDC site visit agendas, feedback comments, and field notes for: 3/25-27/96, 12/10-12/96, and 6/2-4/98,
- CDC site visit agenda and field notes for 8/3-4/99
- CDC Phase II Expectations of Community Partners: Milestones and Documented Origins – Draft August 2, 1999
- CDC Phase II Expectations of Community Partners: Milestones and Indicators
- Memorandums (intra and interoffice) – approximately 82 memos from 4/96 – 3/98
- Interim Process Evaluation and Lessons Learned Report 10/99
- Committee Meeting Schedules February 1996 – March 1998
- Roster of Jacksonville Alliance Advisory Board of Directors
- The National Campaign To Prevent Teen Pregnancy Literature (e.g. fact sheet)
- Campaign Update Newsletters March 1997 – Winter 2000
- The National Conference materials
- The National Strategy to Prevent Teen Pregnancy – U.S. Department of Health and Human Services January 1997
- NOAPPP Network Welfare Reform and Teen Parents Winter 1998
- NOAPPP Network (3 issues)
- Florida Network On Adolescent Pregnancy, Parenting & Prevention
- National Organization on Adolescent Pregnancy, Parenting, and Prevention (NOAPPP)
- Teen Pregnancy Prevention Programs in Jacksonville, Florida literature
- TOPSS Report On The Impact of Teen Pregnancy: An Overview Of Programs In Jacksonville, Florida – April 1993
- 1995 Northeast Florida Directory of Human Services Third Update
- Florida Department of Juvenile Justice Religious Network Initiative literature

- Jacksonville's Community Partnership for the Protection of Children
- Jacksonville Community Council Inc. (JCCI) Teenage Single Parents and Their Families Study Spring 1995
- Report on Unmet Needs Identified by Community Volunteers from Creating a Community Agenda: Indicators for Health and Human Services November 20, 1995
- Jacksonville Community Council Inc. (JCCI) Leadership: Meeting Community Needs Summer 1996
- Jacksonville Community Council Inc. (JCCI) Transportation for the Disadvantaged Summer 1997
- JCCI Teenage Single Parents and Their Families meetings handouts
- First Coast Wages Coalition Program and Financial Plan 1997-1998
- Work Pays for Florida Business brochure
- What Do You See? Report Of The Comprehensive Strategy Task On Serious, Violent And Chronic Juvenile Offenders Jacksonville, Florida May 1998
- Lists of churches in Jacksonville, Florida
- Project S.O.S., Inc. literature
- Community Coalition Partnership Programs for the Prevention of Teen Pregnancy Technical Assistance Workshop Orientation and Community Intervention Strategy Development December 13-15, 1995 Notebook Binder
- Trying to Maximize the Odds: Using What We Know to Prevent Teen Pregnancy (prepared for technical assistance workshop 12/13-15/95) by Susan Philliber and Pearila Namerow
- CDC Technical Assistance Workshop Teen Pregnancy Prevention June 10-13, 1996 Notebook Binder
- CDC Teen Pregnancy Prevention Evaluation Workshop October 3-4, 1996
- Community Organization, Management, Mobilization, and Support Task Force instrument
- Needs and Assets Assessment Task Force instrument
- CDC Cross-Site indicators Time Line

- Community Coalition Demonstration Partnership Program for the Prevention of Teen Pregnancy Timeframes
- CDC Technical Assistance Workshops 1996 NOAPPP Annual Conference October 23-26, 1996 Notebook Binder
- CDC Technical Assistance Workshop March 16-19, 1997 Notebook Binder
- CDC From Theory to Prevention Program Reality November 18, 1997
- Navigating the Political Process: A Global Perspective on the Role of Advocacy and Coalitions in Developing and Sustaining Healthcare Programs for Women and Children by Stephanie L. Ferguson – handout
- Essential characteristic of a "hub" organization in Phase II: "Implementation – Going to Scale" – CDC
- Department of Health and Human Services Public Health Service Centers For Disease Control And Prevention (CDC) – organizational chart as of 12/12/97
- National Center for Chronic Disease Prevention and Health Promotion – organizational chart
- Division of Reproductive Health – organizational chart
- Integrated Planning and Evaluation Tool: The Logical Framework – CDC 1/25-28/98
- Definitions of program, program components, intervention components, activities – handout
- Synthesis of Themes and Sub-themes of the Phase I Needs and Assets Assessments From 13 Communities Participating In The Community Coalition Partnership Program January 23, 1998
- CDC Teen Pregnancy Prevention Program handout
- Orientation! Community Coalition Partnership Programs for the Prevention of Teen Pregnancy handout
- Teen Pregnancy Prevention Program Goals, Philosophy, and Expectations – CDC handout
- CDC Teen Pregnancy Prevention Initiative

Survey

- Community coalition member survey – September 1997 (169 members surveyed, 92 survey received, of which 55% returned completed)

Interviews

- Telephone interview with board member on lessons learned 9/24/99
- Semi-structured interview with board member on lesson learned 9/24/99
- Telephone interview with board member on lessons learned 9/27/99
- Semi-structured interview with staff member of Adolescent Pregnancy Prevention Program on lessons learned 9/27/99
- Semi-structured interview with staff member of Adolescent Pregnancy Prevention Program on lessons learned 9/27/99
- Semi-structured interview with staff member of Adolescent Pregnancy Prevention Program on lesson learned 9/28/99
- Semi-structured interview with board member on lessons learned 10/8/99

Field Notes (include but not limited to):

- General coalition meetings notes from January 1996 to March 1998
- Executive committee meeting notes May 1996 to March 1998
- Staff meeting notes January 1996 to March 1998
- Community leaders meetings notes
- Meeting notes for work group meetings, workshops, inter-agency meeting
- CDC site visit notes
- CDC Technical Assistance Teen Pregnancy Prevention Workshops field notes
- Observation notes of various occurrences

APPENDIX E
SAMPLE OF MEETING MATERIALS

Jacksonville Alliance
for the
Prevention of Adolescent Pregnancy

Alliance Meeting Agenda
May 1, 1996

I. **Welcome and Introductions**

II. **Alliance Committee Update**

III. **Alliance Vision and Mission Statements**

IV. ***Adolescent Pregnancy Issues and Our Community: Learning to Listen to Teens***
Presenter:

V. **Evaluation Overview**

VI. **New Business**

Mark your calendars....
JACKSONVILLE ALLIANCE MEETING
June 27, 1996
5:30 p.m.
FCCJ Urban Resource Center
Guest Speaker:
State Director for PACE Center for Girls

Jacksonville Alliance
for the
Prevention of Adolescent Pregnancy

Alliance Packet Overview

May 1, 1996

- **Mission & Vision Statements**

- ***Adolescent Pregnancy* Presentation Handouts**

- **Adolescent Pregnancy and Sexuality Research...**

"Pregnancy, Abortion, and Birth Rates Among US Adolescents - 1980, 1985, and 1990" (Alison Spitz, MS, MPH, et al, 1996)

"Adolescent Pregnancy in the United States, 1980-1990" (CDC, 1996)

- **Upcoming Committee Meetings: Dates, Times and Locations**

Jacksonville Alliance
for the
PREVENTION OF ADOLESCENT PREGNANCY

Committee Meeting Schedule

May/June 1996

Committee	Day of the Week	Date	Time	Location
Medical	Wednesday	May 15	8:30 a.m.	DCPHU, Conference Room A
Teens	Wednesday	May 15	4:30 p.m.	DCPHU, Conference Room B
Business	Thursday	May 23	8:30 a.m.	Property First Management 11323 Distribution Ave. East
Government	Wednesday	May 29	4:00 p.m.	Duval County Courthouse, Room 504
Media	Thursday	May 30	8:30 a.m.	DCPHU, Conference Room B
Education	Thursday	May 30	3:00 p.m.	DCPHU, Conference Room B
Social Services	Monday	June 3	9:00 p.m.	DCPHU, Conference Room B
Parents	Monday	June 3	4:00 p.m.	DCPHU, Conference Room
Religious	Friday	June 7	8:30 a.m.	Truth for Living Ministries 9497 Lem Turner Road

Alliance Meeting Reminder

June 27, 1996 at 5:30 p.m.

Urban Resource Center

LIST OF REFERENCES

Adrian, Charles R., and Charles Press
1968 Decision Costs In Coalition Formation. American Political Science Review 62(2):556-563.

Arensberg, Conrad M.
1954 Community Study Method. The American Journal of Sociology 60(2):109-124.

1955 American Communities. American Anthropologist 57(6): 1143-1162.

Bailey, Darlyne
1992 Using Participatory Research in Community Consortia Development and Evaluation: Lessons from the Beginning of a Story. The American Sociologist 23(4):71-82.

Bass, Leslie L., David A. Dosser, Jr., and John Y. Powell
2001 Words Can Be Powerful: Changing the Words of Helping to Enhance Systems of Care. Journal of Family Social Work 5(3):35-48.

Becker, Fred W., and Milan J. Dluhy
1998 Solving Problems In Urban Areas Characterized By Fragmentation And Divisiveness: An Overview. Research in Urban Policy 7:1-16.

Bellah, Robert N., Richard Madsen, William M. Sullivan, Ann Swidler, and Steven M. Tipton
1985 Habits of the Heart: Individualism and Commitment in American Life. Berkley, CA: University of California Press.

Bender, Thomas
1978 Community and Social Change in America. New Brunswick, NJ: Rutgers University Press.

Black, Terry R.
1983 Coalition Building-Some Suggestions. Child Welfare 62(3):263-268.

Blum, Arthur, and Ibrahim Ragab
1985 Developmental Stages of Neighborhood Organizations. Social Policy 15(4):21- 28.

Bodo, Kim, Jackie Kendall, and Steve Max
1991 Organize for Social Change: A Manual for Activists in the 1990s. Washington, DC: Seven Locks Press.

Brannen, Mary Yoko, and Jane E. Salk
2000 Partnering Across Borders: Negotiating Organizational Culture in a German-Japanese Joint Venture. Human Relations 53(4):451-487.

Burdell, Patricia
1998 Young Mothers as High School Students: Moving Toward a New Century. Education and Urban Society 30(2):207-223.

Butterfoss, Frances Dunn, Robert M. Goodman, and Abraham Wandersman
1993 Community Coalitions for Prevention and Health Promotion. Health Education Research: Theory and Practice 8(3):315-330.

Camino, Linda A.
1997 What Can Anthropologists Offer Ethnographic Program Evaluation? *In* Practicing Anthropology in a Postmodern World: Lessons and Insights from Federal Contract Research. NAPA Bulletin 17. Michael C. Reeds, ed. Pp.41-57. Washington, DC: American Anthropological Association.

Center for Substance Abuse Prevention
1997 Effective Community Mobilization: Lessons From Experience. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Centers for Disease Control and Prevention
1995 Program Announcement 547 Community Coalition Partnership Programs for the Prevention of Teen Pregnancy. Department of Health and Human Services.

1997 Principles of Community Engagement. Atlanta, GA: Public Health Practice Program Office.

Chagnon, Napolean A.
1992 Yanomano: The Fierce People. Third Edition. New York: Holt, Rinehart, and Winston.

Chavis, David M., and J. R. Newbrough
1986 The Meaning of "Community" in Community Psychology. Journal of Community Psychology 14(4):335-340.

Cohen, Anthony B.
1985 The Symbolic Construction of Community. New York: Tavistock Publications.

Creswell, John W.
1994 Research Design Qualitative and Quantitative Approaches. Thousand Oaks, CA: Sage Publications.

1998 Qualitative Inquiry and Research Design. Choosing Among Five Traditions. Thousand Oaks, CA: Sage Publications.

Dollard, John
1949 Caste and Class in a Southern Town. Second Edition. New York: Harper.

Eng, Eugenia, and Edith Parker
1994 Measuring Community Competence in the Mississippi Delta: The Interface between Program Evaluation and Empowerment. Health Education Quarterly 21(2):199-220.

Fawcett, Stephen B., Rhonda K. Lewis, Adrienne Paine-Andrews, Vincent T. Francisco, Kimber P. Richter, Ella L. Williams, and Barbara Copple
1997 Evaluating Community Coalitions for Prevention of Substance Abuse: The Case of Project Freedom. Health Education and Behavior 24(6):812-828.

Florence, Jill M., Tim G. Conner, and D. Paul Moberg
1994 Interim Evaluation of the Dane County Partners in Prevention Program. Madison: University of Wisconsin-Madison Medical.

Florida Tobacco Control Clearinghouse
1999 Guide to Creating Community Partnerships. Tallahassee, FL: Florida Department of Health and Office of Tobacco Control.

Florin, Paul, Roger Mitchell, and John Stevenson
1993 Identifying Technical Needs In Community Coalitions: A Developmental Approach. Health Education Research Theory and Practice 8(3):417-432.

Francisco, Vincent T., Adrienne L. Paine, and Stephen B. Fawcett
1993 A Methodology for Monitoring and Evaluating Community Health Coalitions. Health Education Research Theory and Practice 8(3):403-416.

Germain, Carol P.
1993 Ethnography: The Method. *In* Nursing Research A Qualitative Perspective. Patricia L. Munhall and Carolyn Oiler Boyd, eds. Pp. 237-268. New York: National League for Nursing Press.

Goodman, Robert M., and Abraham Wandersman
1994 FORECAST: A Formative Approach to Evaluating Community Coalitions and Community-Based Initiatives. Journal of Community Psychology. CSAP Special Issue, Pp. 6-25.

Gorer, Geoffrey
1964 The American People, A Study In National Character. New York: Norton.

Greenwood, Davydd J., and Morten Levin
1998 Introduction to Action Research Social Research for Social Change. Thousand Oaks: Sage Publications.

Gregory, Kathleen L.
1983 Native-view Paradigms: Multiple Cultures and Culture Conflicts in Organizations. Administrative Science Quarterly 28(3):359-376.

Hall, Shirley
1988 The Graying and Transformation of a Retirement Village. PhD dissertation, University of Florida.

Hall, Edward T. and Mildred Reed Hall
1989 Understanding Cultural Differences: Keys to Success in West Germany, France, and the United States. Maine: Intercultural Press.

Hochschild, Arlie R.
1973 The Unexpected Community. Berkeley: University of California Press.

Israel, Barbara, Barry Checkoway, Amy Schulz, and Marc Zimmerman
1994 Health Education and Community Empowerment: Conceptualizing and Measuring Perceptions of Individual, Organizational, and Community Control. Health Education Quarterly 21(2):149-170.

Kang, Rebecca
1995 Building Community Capacity for Health Promotion: A Challenge for Public Health Nurses. Public Health Nursing 12(5): 312-318.

Kegler, Michelle Crozier
1995 Literature Review. *In* Community Coalitions for Tobacco Control: Factors Influencing Implementation. Chapter 2. PhD dissertation, University of North Carolina Pp. 17-43.

Kegler, Michelle Crozier, Allan Steckler, Kenneth McLeroy, and Sally Herndon Malek
1998 Factors That Contribute to Effective Community Health Promotion Coalitions: A Study of 10 Project ASSIST Coalitions in North Carolina. Health Education and Behavior 25(3):338-353.

Kirby, Douglas
1997 No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy (Summary). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

Kingsley, G. Thomas, Joseph B. McNeely, and James O. Gibson
1997 Community Building Coming Of Age. The Development Training Institute, Inc., and The Urban Institute.

Kruger, Arnold
2000 Empowerment In Social Work Practice With The Psychiatrically Disabled: Model and Method. Smith College in Social Work 70(3):427-439.

Liebow, Elliot
1967 Tally's Corner: A Study of Negro Streetcorner Men. Boston: Little, Brown, And Company.

Lynd, Robert S. and Helen Merrell Lynd
1929 Middletown A Study in American Culture. New York: Harcourt, Brace And Company.

1937 Middletown in Transition. New York: Harcourt, Brace And Company

Maccoby, Michael
1997 Learning to Partner and Partnering to Learn. Research Technology Management 40(3):55-57.

Mattessich, Paul W., and Barbara R. Monsey
1992 Collaboration: What Makes It Work. A Review of the Literature on Factors Influencing Successful Collaboration. St. Paul, MN: Amherst H. Wilder Foundation.

Mattessich, Paul W., Barbara R. Monsey, and Corrina Roy
1997 Community Building: What Makes It Work. A Review of Factors Influencing Successful Community Building. St. Paul, MN: Amherst H. Wilder Foundation.

McMillan, David W., and David M. Chavis
1986 Sense of Community: A Definition and Theory. Journal of Community Psychology 14(1):6-23.

Mizrahi, Terry
1999 Strategies for Effective Collaborations in the Human Services. Social Policy 29(4):5-20.

Nader, Laura
1988 Up The Anthropologist - Perspectives Gained From Studying Up. *In* Anthropology For The Nineties. Johnnetta B. Cole, ed. Pp. 470-484. New York: The Free Press.

Nezlek, John B., and Joseph Galano
1993 Developing and Maintaining Statewide Adolescent Pregnancy Prevention Coalitions: A Preliminary Investigation. Health Education Research Theory and Practice 8(3):433-447.

Poole, Dennis L., and Mary Van Hook
1997 Retooling for Community Health Partnerships in Primary Care and Prevention. Health & Social Work 22(1):1-4.

Rodriquez, Cleo Jr., and Nelwyn B. Moore
1995 Perceptions of Pregnant/Parenting Teens: Reframing issues for an Integrated Approach to Pregnancy Problems. Adolescence 30(119):685-699.

Sahlins, Marshall
1972 Stone Age Economics. New York: Aldine De Gruyter.

Scheirer, Mary Ann
1994 Designing and Using Process Evaluation. *In* Handbook of Practical Program Evaluation. Joseph S. Wholey, Harry P. Hatry and Kathryn E. Newcomer, Eds. Pp. 40-68.

Schwartz, Norman B.
1981 Anthropological Views of Community and Community Development. Human Organization 40(4):313-322.

Sennett and Cobb
1973 The Hidden Injuries of Class. New York: Vintage Books.

Spradley, James
1980 Participant Observation. New York: Holt, Rinehart and Winston.

Stack, Carol B.
1974 All Our Kin: Strategies for Survival in a Black Community. New York: Harper & Row.

Stein, Maurice R.
1960 The Eclipse of Community: An Interpretation of American Studies. Princeton, NJ: Princeton University Press.

Suttles, Gerald D.
1972 The Social Construction of Communities. Chicago, IL: University of Chicago Press.

Valentine, Bettylou
1978 Hustling And Other Hard Work: Lifestyles In The Ghetto. New York: Free Press.

Vidich, Arthur J., Joseph Bensman, and Maurice R. Stein (eds.)
1964 Reflections on Community Studies. New York: John Wiley and Sons, Inc.

Wallerstein, Nina and Edward Bernstein
1994 Introduction to Community Empowerment, Participatory Education, and Health. Health Education Quarterly 21(2):141-148.

Wandersman, Abraham
1999 Community Interventions and Effective Prevention: Bringing Researchers/Evaluators, Funders and Practitioners Together to Promote Accountability. Draft manuscript for Special Issue of American Psychologist.

Wandersman, Abraham, Robert M. Goodman, and Frances D. Butterfoss
1996 Understanding Coalitions and How They Operate. An "Open Systems" Organizational Framework. *In* Community Organizing and Community Building for Health. Minter, First Pass Pages Pp. 261-271.

Warner, W. Lloyd, and Paul S. Lunt
1941 The Social Life of a Modern Community. Yankee City Series 1. New Haven: Yale University Press.

Warren, Roland L
1978 The Community in America. Third Edition. Chicago: Rand McNally Publishing Company.

Warshaw, Carole
1989 Limitations of the Medical Model in the Care of Battered Women. Gender and Society 3(4):506-517 Special Issue.

Whyte, William Foote
1981 Street Corner Society: The Social Structure of an Italian Slum. Third Edition, Revised and Expanded. Chicago: The University of Chicago Press.

Williams, Holly Ann
1995 There Are No Free Gifts! Social Support and the Need for Reciprocity. Human Organization 54(4):401-409.

Wolcott, Harry F.
1999 Ethnography A Way Of Seeing. Walnut Creek, CA: AltaMira Press.

BIOGRAPHICAL SKETCH

Ms. Sabrina Nichelle Scott graduated from Barnard College, Columbia University, in May 1987. She majored in anthropology and minored in economics. In her junior year, Ms. Scott became interested in business anthropology. While at Barnard, she became active in student government. Ms. Scott was elected by her peers to serve as Junior Class Vice President and Senior Class President.

After working on Wall Street for eight months, in August 1988, Ms. Scott relocated to Jacksonville, Florida, to become the primary caregiver to her paternal grandmother. In August 1989, the current dean of the Coggin College of Business, University of North Florida, recruited Ms. Scott to attend the MBA program. While in the MBA program, she worked part-time as a graduate research assistant for the Office of the Dean.

After receiving her MBA in August 1992, Ms. Scott immediately enrolled in the PhD program in cultural anthropology at the University of Florida. In 1994, Ms. Scott was elected and served a two-year term as student representative to the Governing Council for the National Association of Practicing Anthropologists. In 1998, while pursuing her PhD and working full-time for the Duval County Health Department, Ms. Scott became an Adjunct Instructor in the Department of Sociology and Anthropology at the University of North Florida. She enjoyed teaching and developing the curriculum for a course entitled Peoples and Cultures of the World.

In her spare time, Ms. Scott enjoys traveling with family and friends. She loves to attend church and listen to gospel music. Ms. Scott looks forward to pursuing her

research interests in community coalition partnerships, organizational culture and development, and comparative management.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Otto Von Mering, Chair
Professor Emeritus of Anthropology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Paul Doughty
Distinguished Service Professor
Emeritus of Anthropology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Robert M. Weiler
Associate Professor of Health
Science Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Elizabeth K. Briody
Staff Research Scientist of General
Motors Research and Development
Development Center
Warren, Michigan

This dissertation was submitted to the Graduate Faculty of the Department of Anthropology in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

May 2003

Dean, Graduate School